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GYNÆCOLOGICAL PLATES TAKEN FROM DISEASES OF WOMEN AND UTERINE THERAPEUTICS

NINTH EDITION

These plates have been reprinted for circulation amongst a few personal friends, to whom I am indebted for many kindnesses.

H. MACNAUGHTON-JONES.

OCTOBER, 1904.

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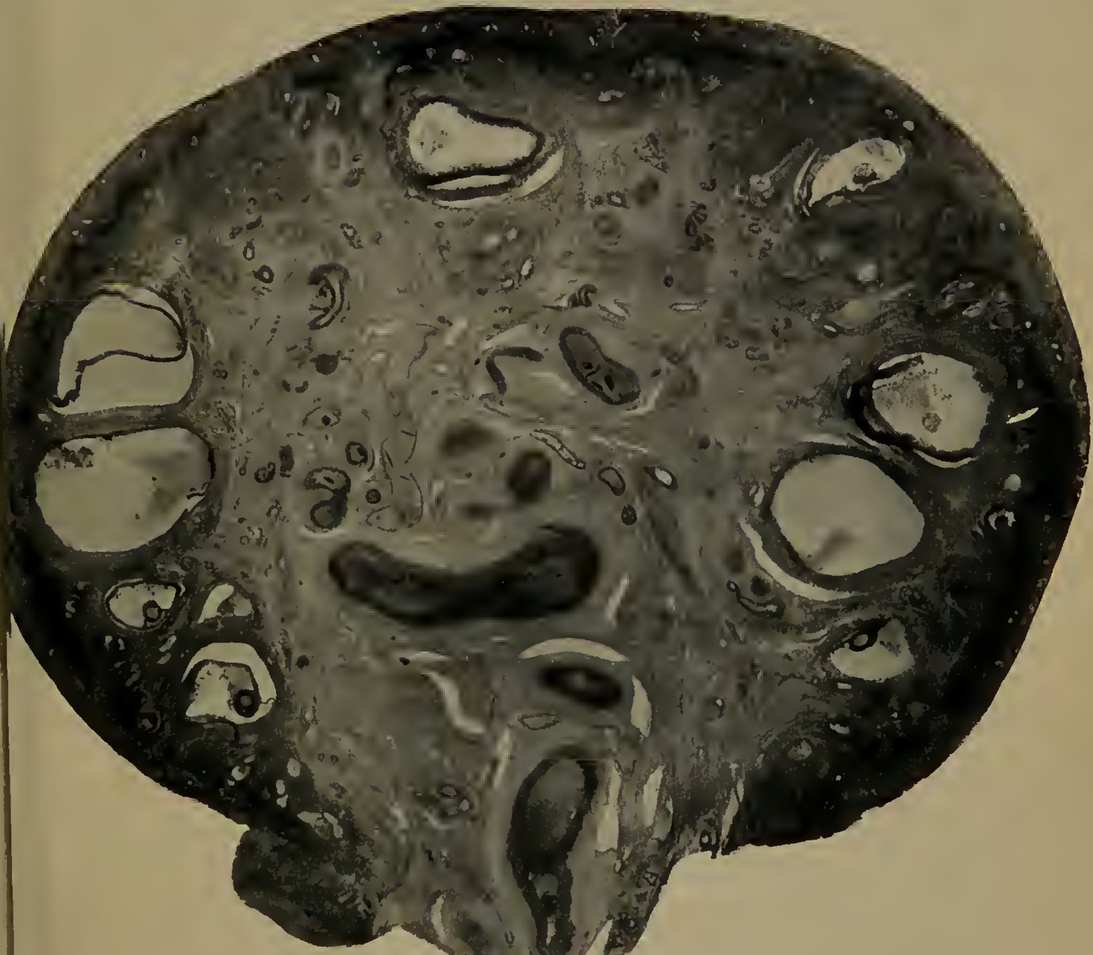
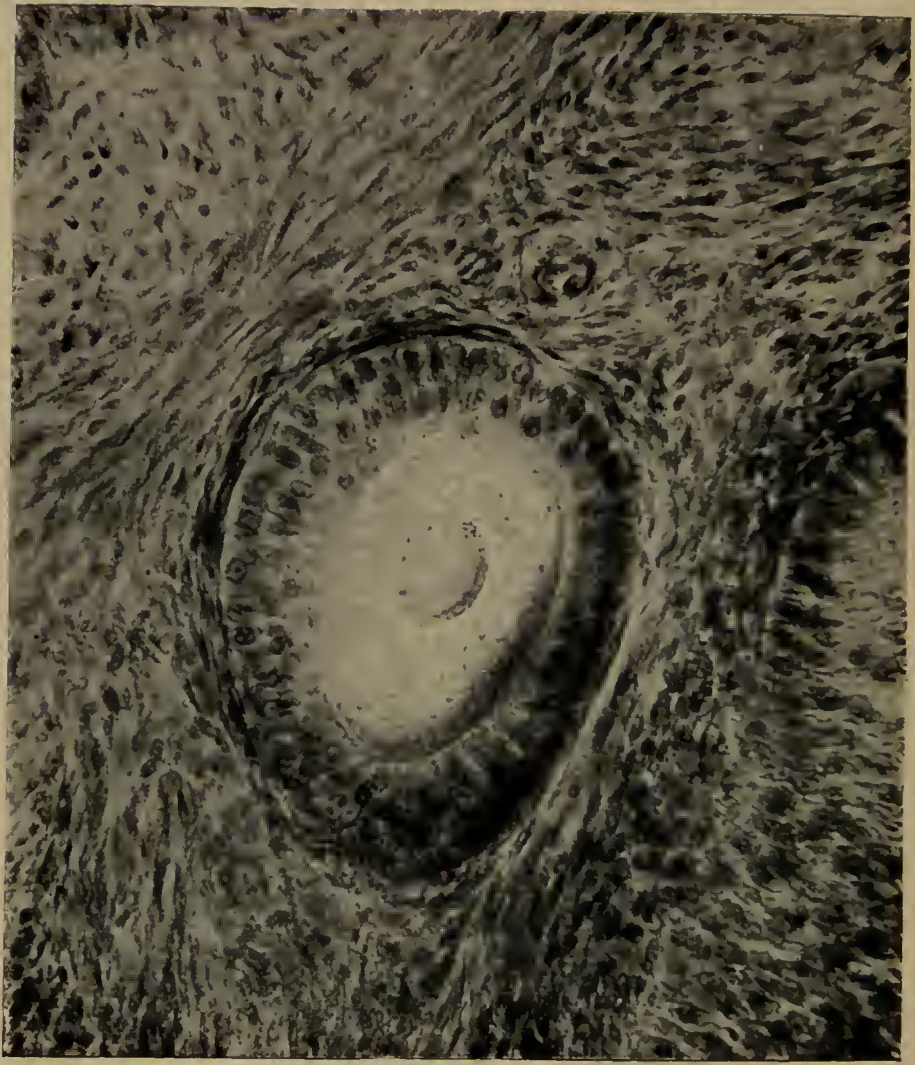


SECTION OF THE MATURE OVARY, ILLUSTRATING THE VARIOUS STAGES IN THE DEVELOPMENT AND REGRESSION OF THE GRAÄFIAN FOLLICLES.

Within some of the follicles the discus proligerus is clearly visible. Some have undergone cystic degeneration, while others are represented by corpora lutea in various stages of cicatrization. (× 30 times.)

[*To face p.* 28.

PLATE *B.*



Human Ovum.

Shows under a high magnification (upwards of 400 diameters), a partially matured Graäfian follicle lying in the ovary. In the centre is seen the nucleus of the ovum, containing a nucleolus, and surrounded by the granular protoplasm of the ovum. The zona pellucida—the hyaline limiting membrane of the ovum—is visible, though not yet fully formed. Outside it is the membrana granulosa, consisting, at this stage, of a double layer of cubical cells, with radially arranged nuclei. Most externally the ovarian stroma in the neighbourhood is becoming condensed to form the tunica fibrosa. The cells of the tunica granulosa have not yet commenced to form the liquor folliculi.

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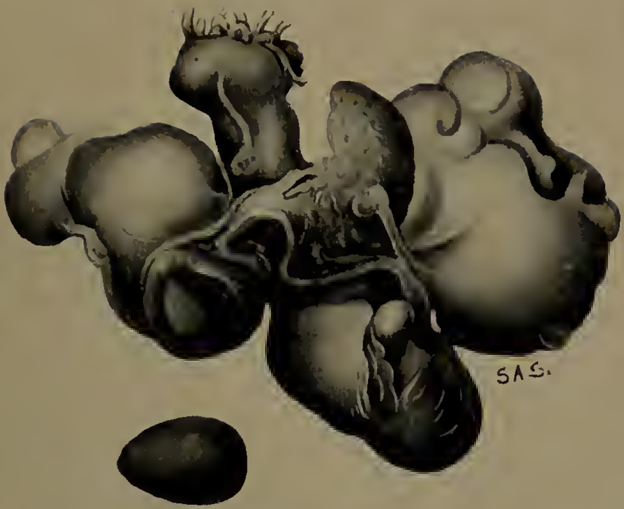
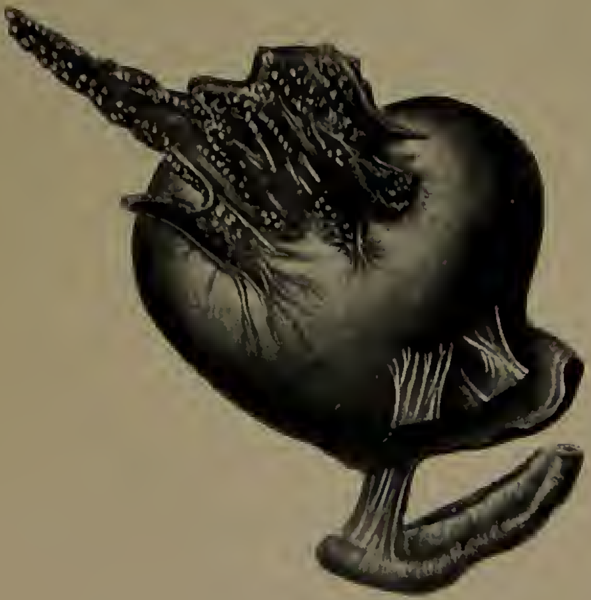
PLATE I.



APPENDIX, FALLOPIAN TUBE AND CYSTIC OVARY. (AUTHOR.)

The removed concretion is the natural size. The second is seen filling the lumen of the appendix. Recovery. (See page 43.)

PLATE II.



AN OVARIAN CYST WITH OMENTAL ADHESIONS ABOVE AND AN ADHERENT VERMIFORM APPENDIX BELOW. (KELLY.)

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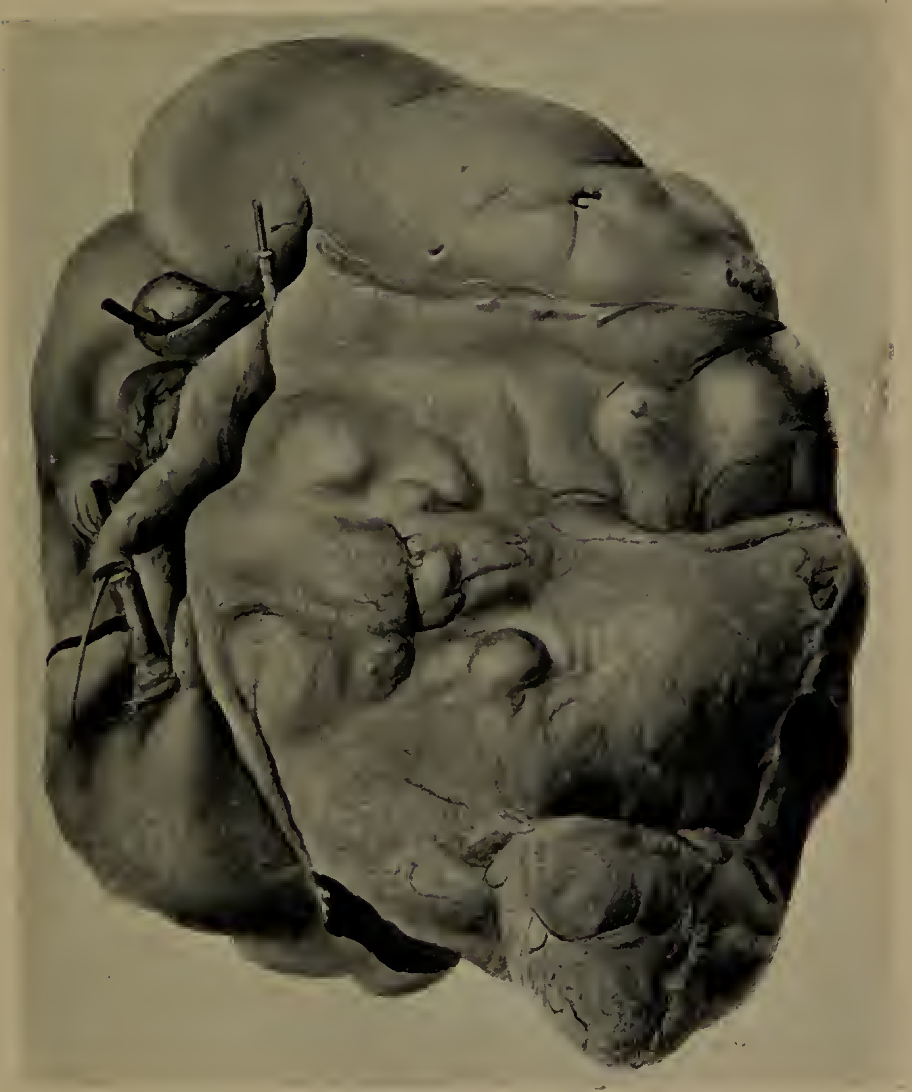
PLATE III.

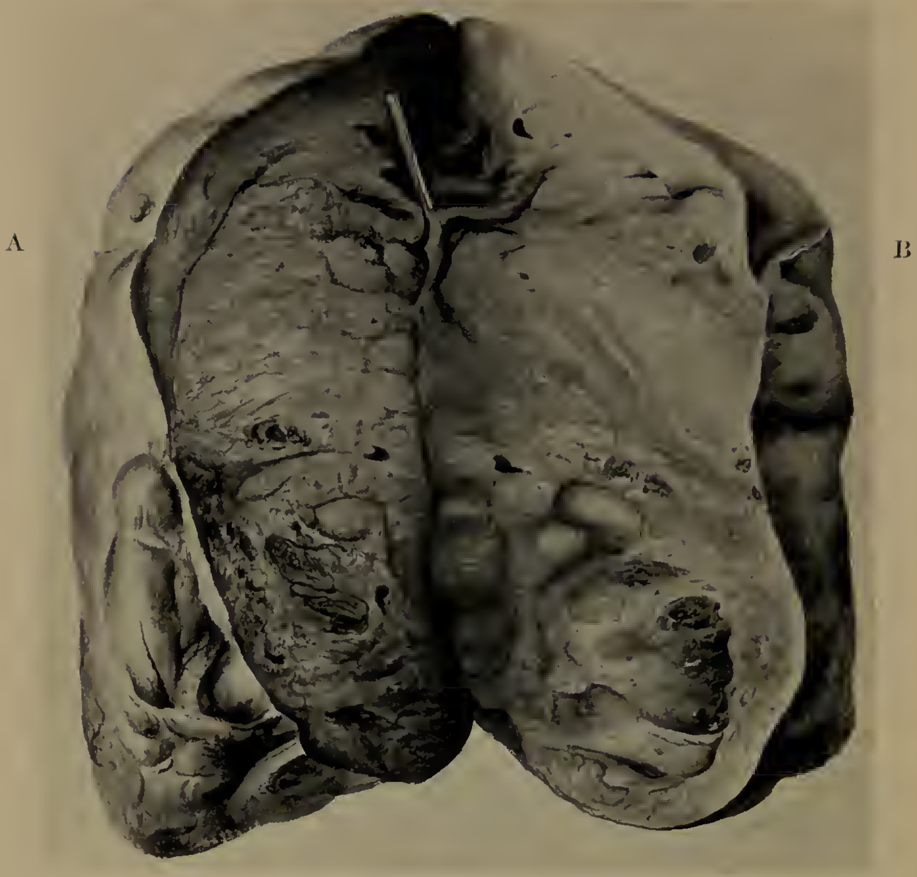


Carcinoma of a Large Mobile Kidney. (Author.)

The hilum and the renal veins are invaded with new growth; the ureter is healthy, and is seen cut across. Nephrectomy. Recovery. (Page 45.)

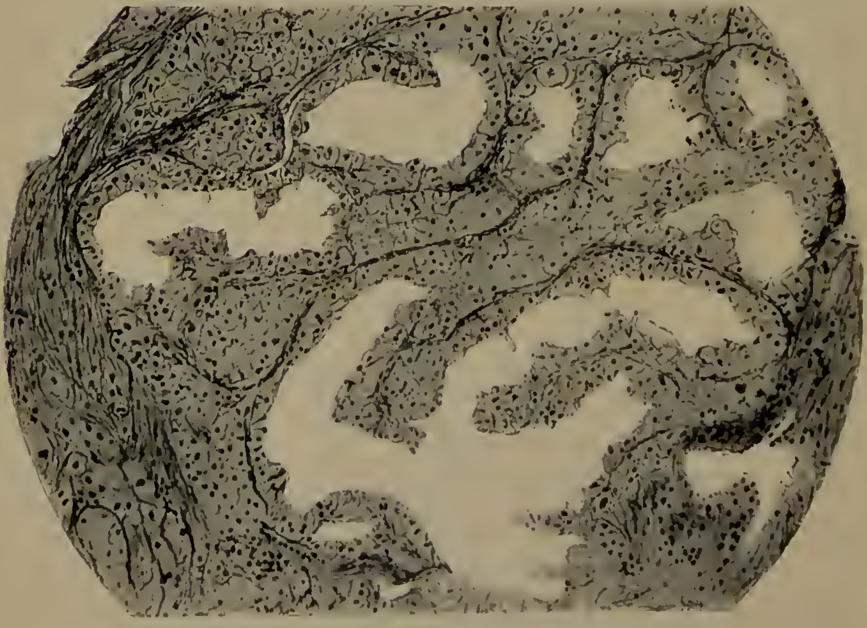
[*To face p.* 44.

PLATE IV.



THE SAME KIDNEY SHOWN IN SECTION. (AUTHOR.)

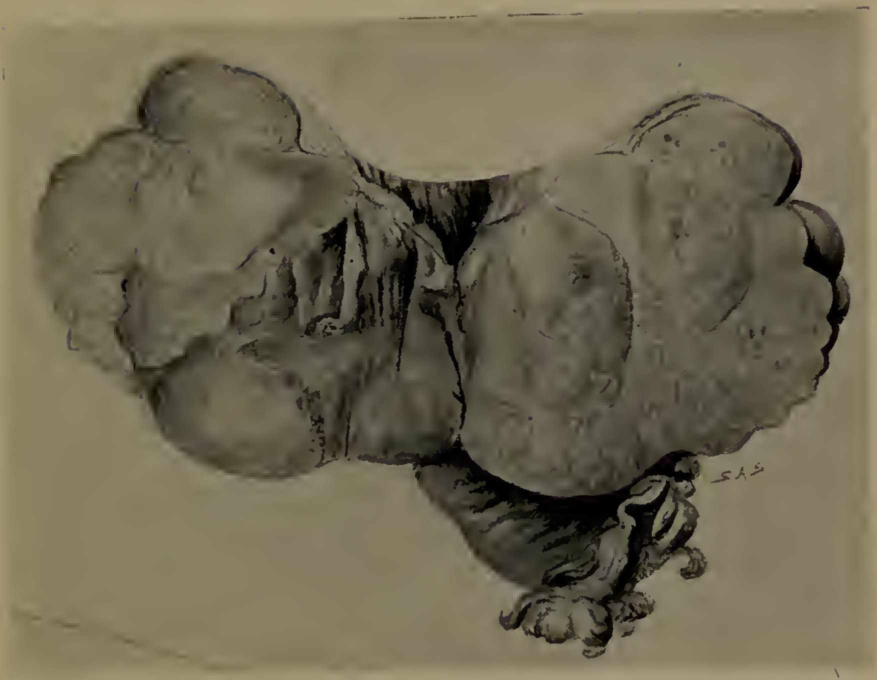
The area of healthy structure is limited by a line drawn from A to B. Nephrectomy. Recovery. (Page 45.)



SECTION FROM CARCINOMATOUS AREA.

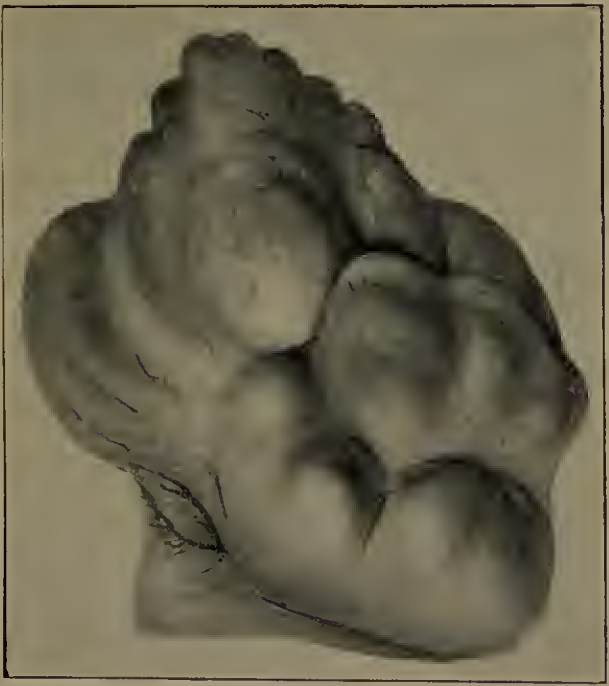
[*To face p.* 45.

PLATE V.



Fibro-adenoma of the Ovary occurring with a Fibromyomatous Uterus. (Author.)

Abdominal Salpingo-Oöphorectomy.



To show Lobulated External Surface of the Tumour.

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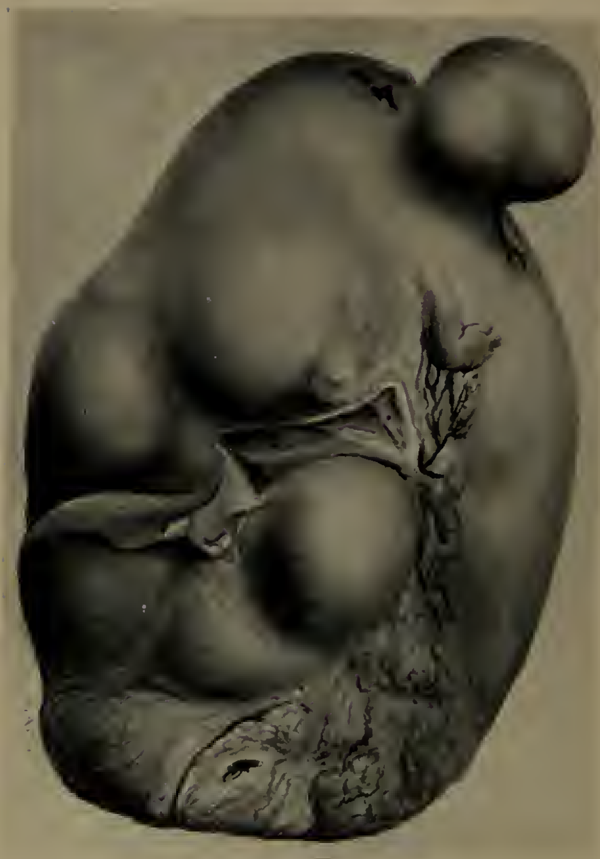
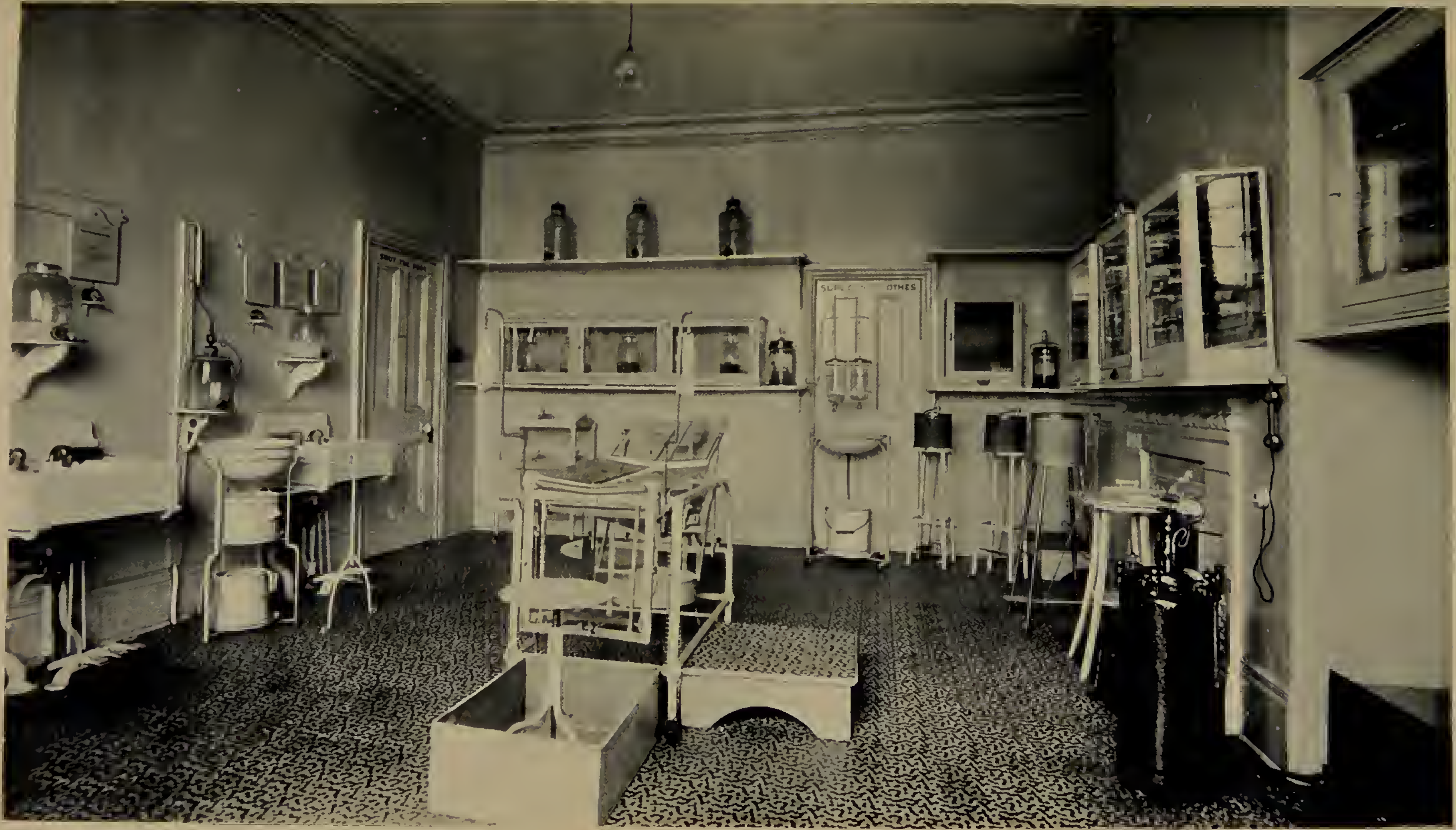
PLATE VI.



Fibromyomatous Uterus removed from the same Patient from whom the Ovary (Plate V.) was taken. Recovery. (Author.)

[*To face p.* 63.

PLATE VII.

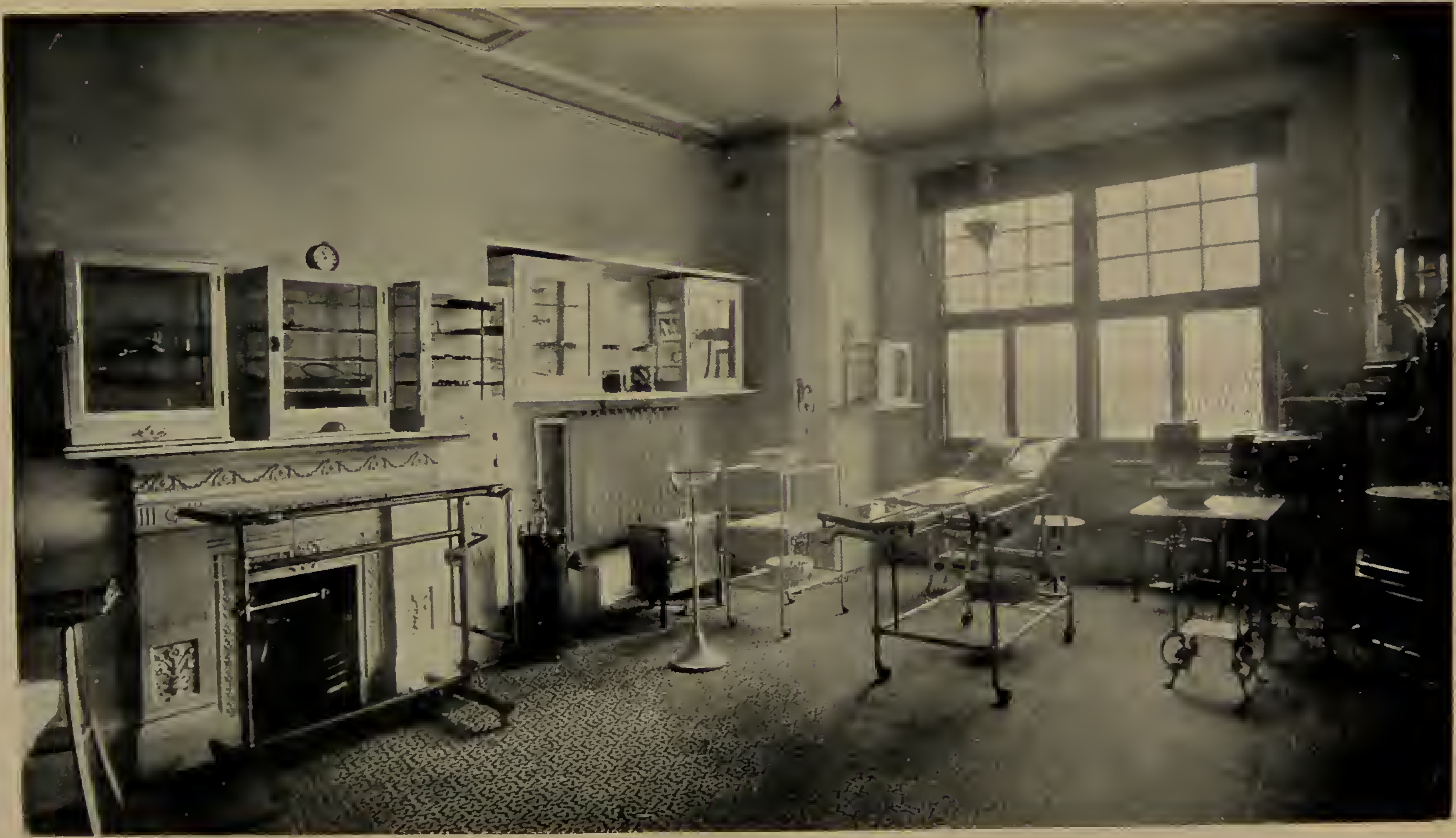


OPERATING THEATRE (ST. RONANS').

Showing table; pedal sinks (with jars containing lysoform); over these small clocks, to time sterilization of hands and arms according to instructions suspended over the sinks; Pasteur's filter; lavabos; pedal baskets for dressings, compresses, and dabs; sterilizer for moist dressings, etc.

[*To face p.* 110.

PLATE VIII.

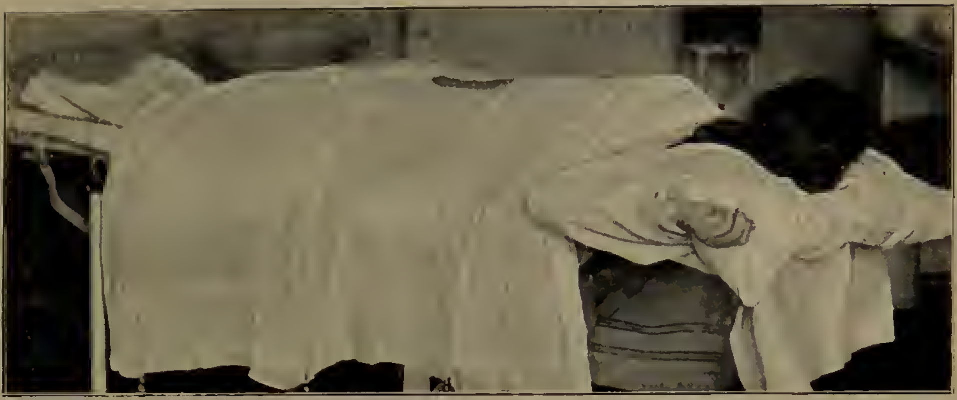


Another View of same Theatre.

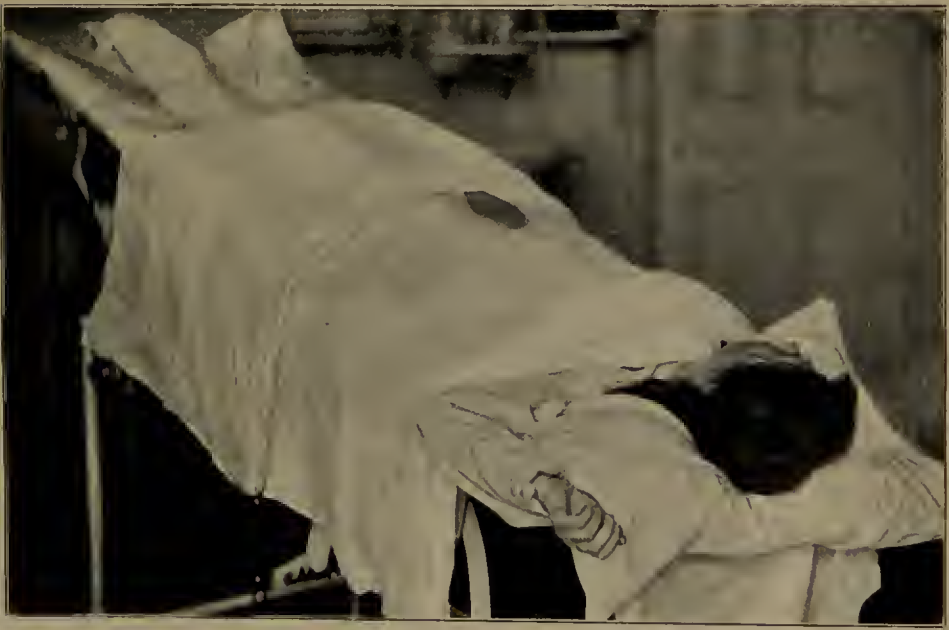
With second table to the left (Greig Smith's); sterilizers, etc.; also transformer for cautery, and lavabo for douching and holding artificial serum.
(See p. 112. Figs. 85, 86.)

[*To face p.* 111.

PLATE IX.



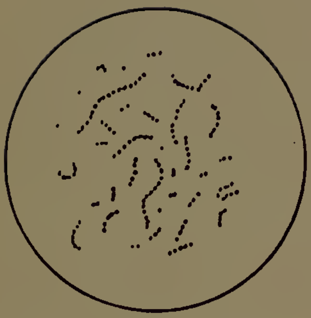
Patient prepared for Operation—Woollen Jacket, Muslin Slips held by Light Clamp or Sponge Holders; Sack Drawers are drawn over Woollen Stockings (all Sterilized). (See p. 129.)



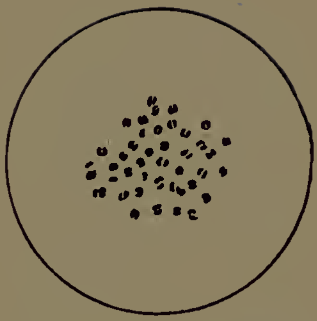
Same in Partial Trendelenburg Position.

[*To face p.* 128.

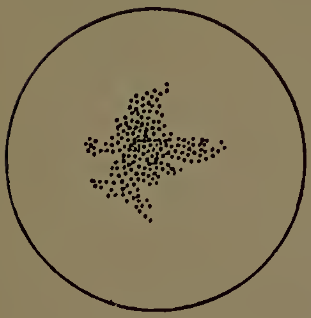
PLATE X.



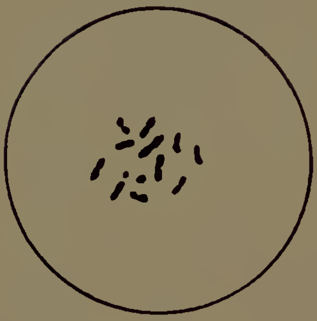
Streptococcus Pyogenes
(1 × 1000).



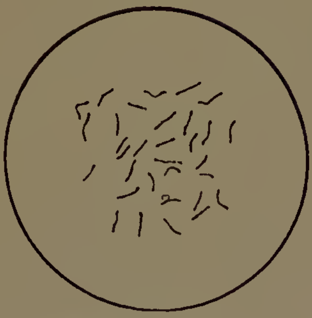
Gonococcus (Neisser)
(1 × 1000).



Staphylococcus Pyogenes
(1 × 1000).



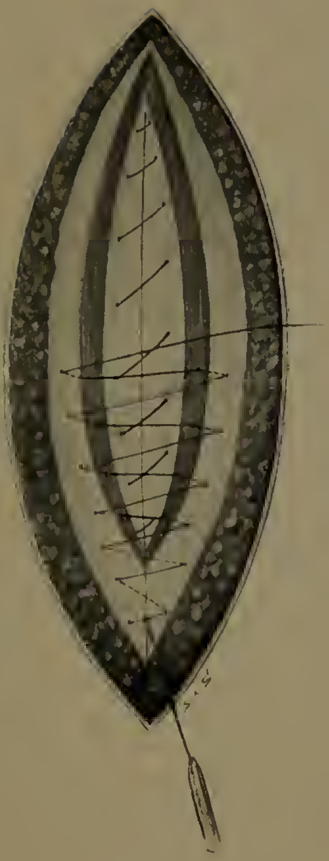
B. Coli Communis
(1 × 1000).



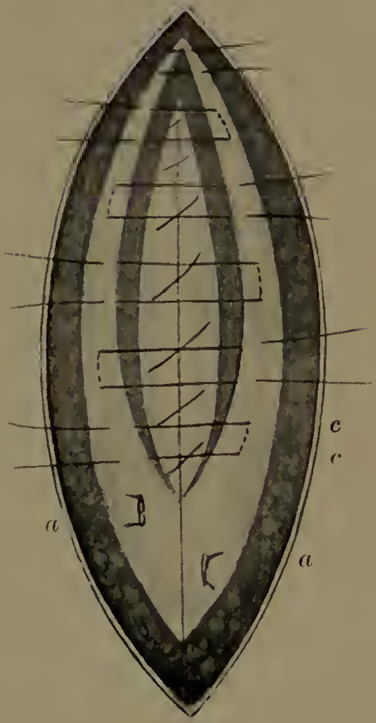
B. Tuberculosis (1 × 1000).

[*To face p.* 137.

PLATE XI.



A.



B.

A. Showing the Closure of the Abdominal Wound. (Author.)

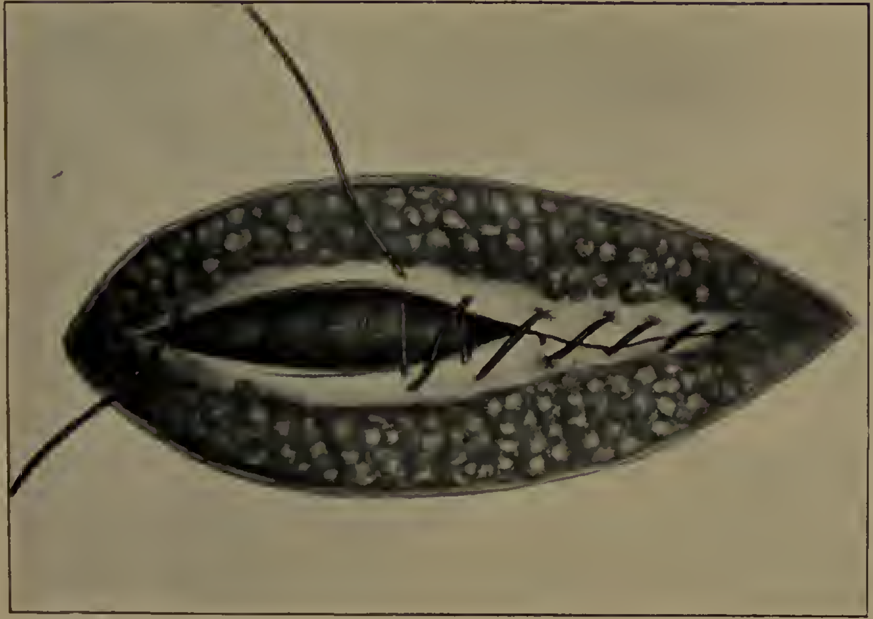
The peritoneum is united by a continuous suture of cumol gut. The aponeurosis is freed from the rectus muscle at either side. The needle is then made to traverse the fascia, take up a loop of muscle at either side with the fascia (shown in the dotted lines), which is then perfectly adjusted, its edges in perfect apposition. The skin is then closed with celloidinzwirn or bronze aluminium wire.

B. Closure of the Fascia by Mattress Suture, after C. Noble's Method.

a, *a*, two first sutures tied. Two straight needles are threaded with a single thread—one is carried through the fascia *from beneath* at *c*, and the thread is then carried over and made to pierce the fascia underneath at the opposite side; the other needle pursues the same course, the loops being placed alternately.

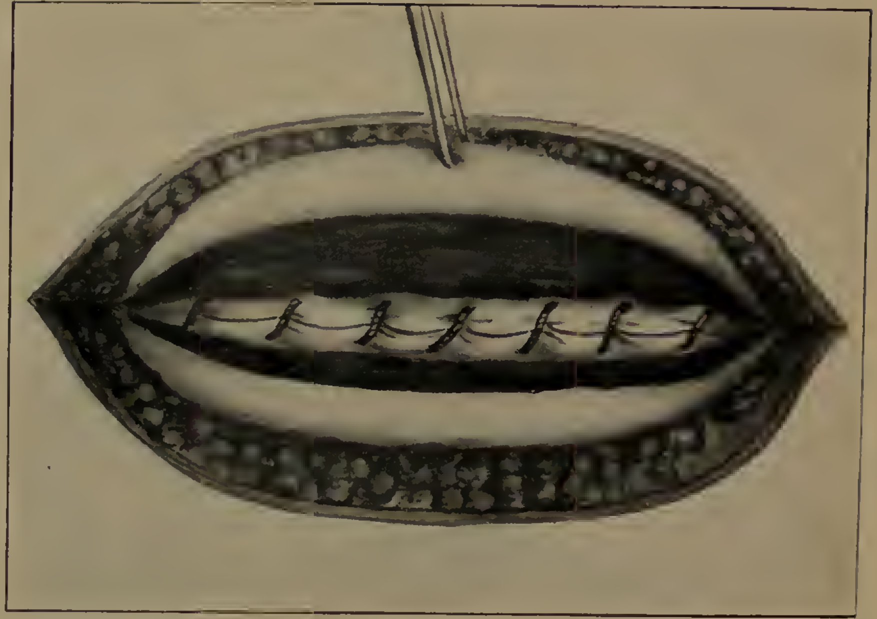
[*To face p.* 170.

PLATE XII.



Showing the Wound in the Rectus closed with Continuous Catgut Suture; Closure of the Aponeurosis by superimposing the Right Aponeurosis upon the Left and Suturing it with special form of Continuous Catgut Suture. (Noble.)

It will be seen that Noble closes the muscle by a separate suture.

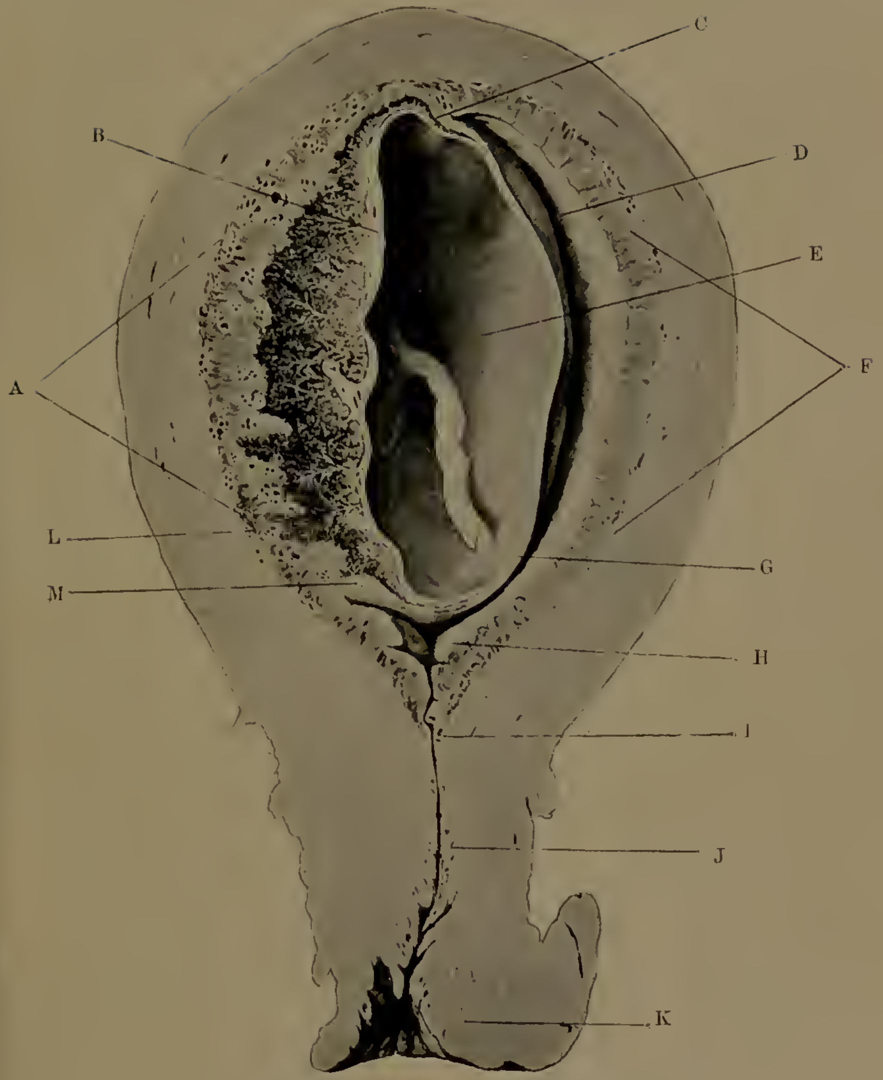


Showing Closure of Peritoneum with Continuous Catgut Suture; the Borders of the (divided) Rectus Muscle; the Left Aponeurosis freed from the layer of Fat; the Right Aponeurosis separated from the Rectus Muscle and reflected. (Noble.)

In a more recent method he uses the mattress suture for the fascia.

[*To face p.* 171.

PLATE XIII.



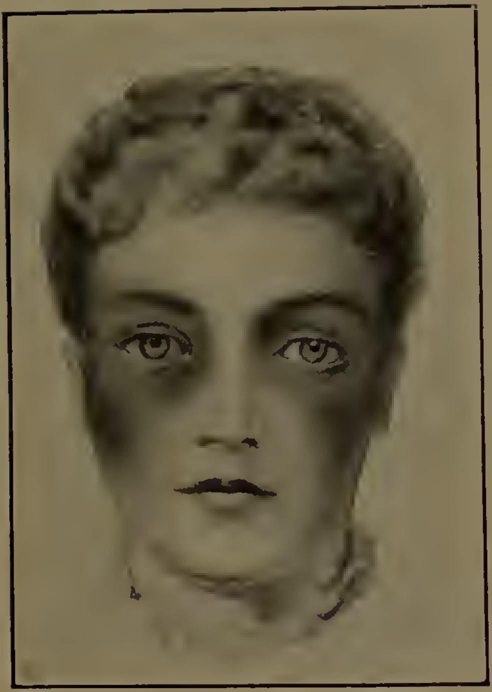
UTERUS GRAVID. THIRD MONTH. (BUMM.)

A, decidua serotinæ; B, chorionic membrane; C, starting-point of the decidua reflexa; D, uterine cavity; E, cavity of the ovum; F, decidua vera; C, G, decidua reflexa and chorion; H, lower part of uterine cavity; I, cervical canal; J, internal os; K, external os; L, enlarged serotinal arteries; M, starting-point of decidua reflexa.

[*To face p.* 173.

⁂ The author is enabled to insert this photograph through the courtesy of Professor Bumm, who sent him the original copy.

PLATE XIIIa.



Vasomotor Coloration of Face with Pigmentary Changes associated with Violent Dysmenorrhœa and Oöphoralgia. (Author.)

[*To face p.* 188.

PLATE XIV.

Case I.

FIBROMATOUS UTERUS REMOVED BY VAGINAL HYSTERECTOMY FOR PROLAPSE OF 15 YEARS' STANDING, SHOWING ADHESIONS. RETURN OF THE BLADDER INTO THE PELVIC CAVITY. (AUTHOR.)

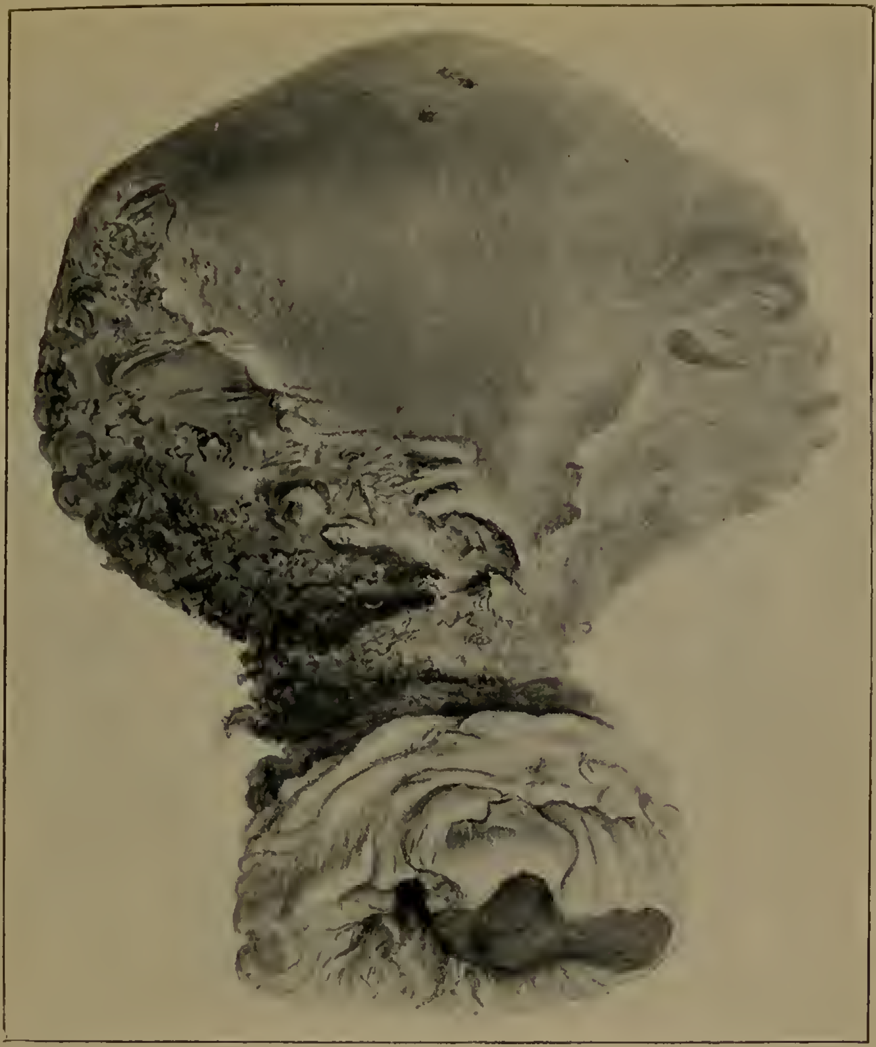
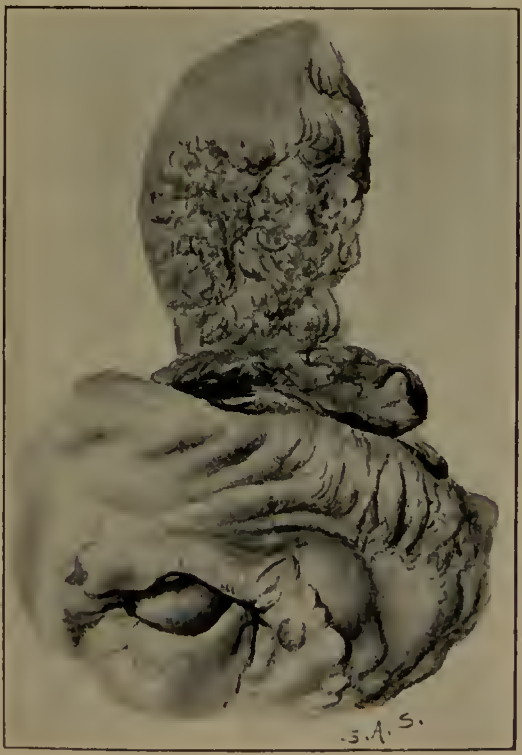


PLATE XV.

Case II.

SENILE ATROPHIC UTERUS REMOVED FROM PROCIDENT SAC AFTER THE RETURN OF THE BLADDER AND RECTUM INTO THE PELVIC CAVITY, IN A PATIENT AGED 74. (AUTHOR.)

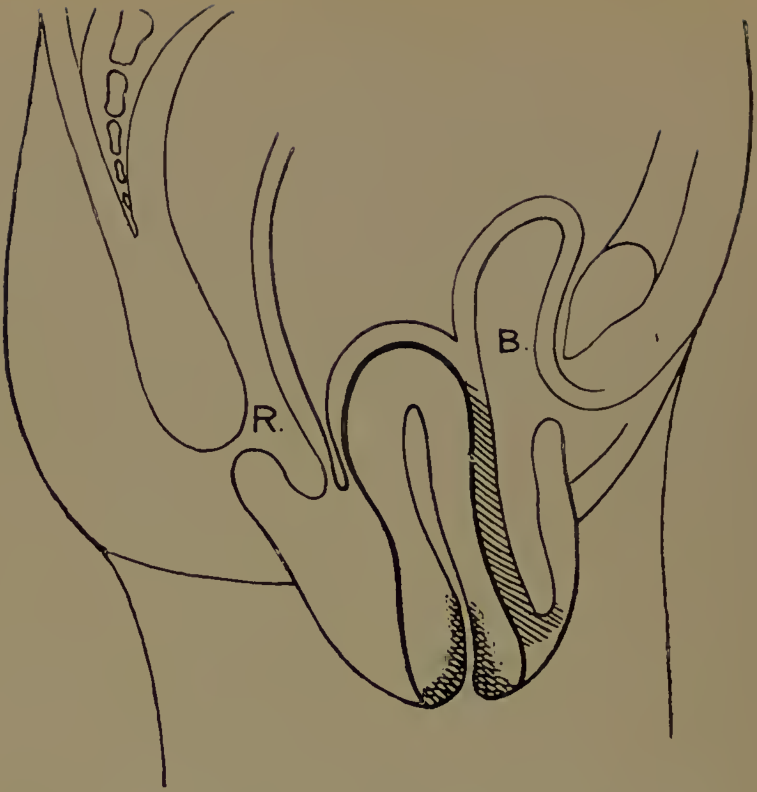
Prolapse of twenty-five years' duration.



See reverse side for diagrammatic sections of Cases I. and II.

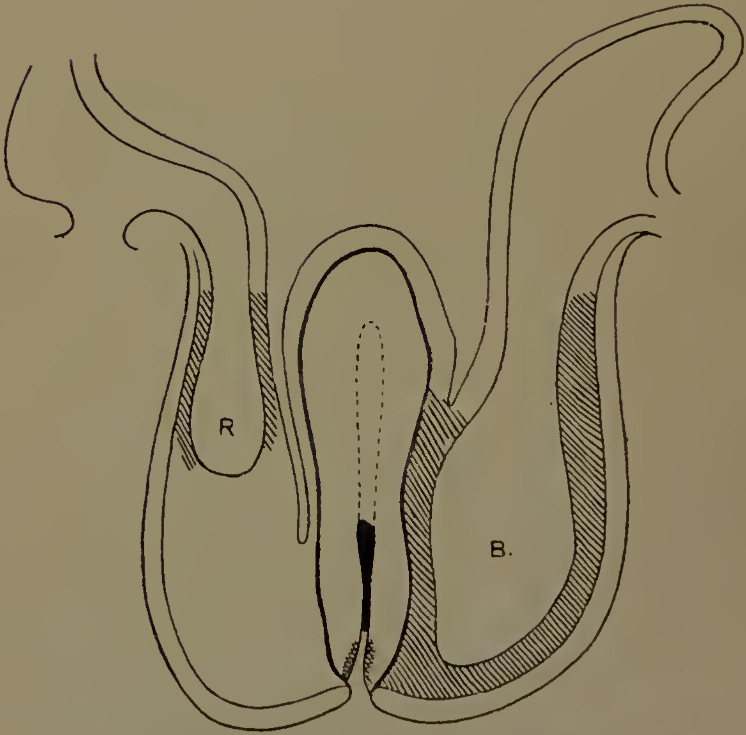
[*To face* p. 308.

PLATE XVI.



Case I. (p. 308).—Sectional Drawing, showing Extent of Adhesions to the Bladder.

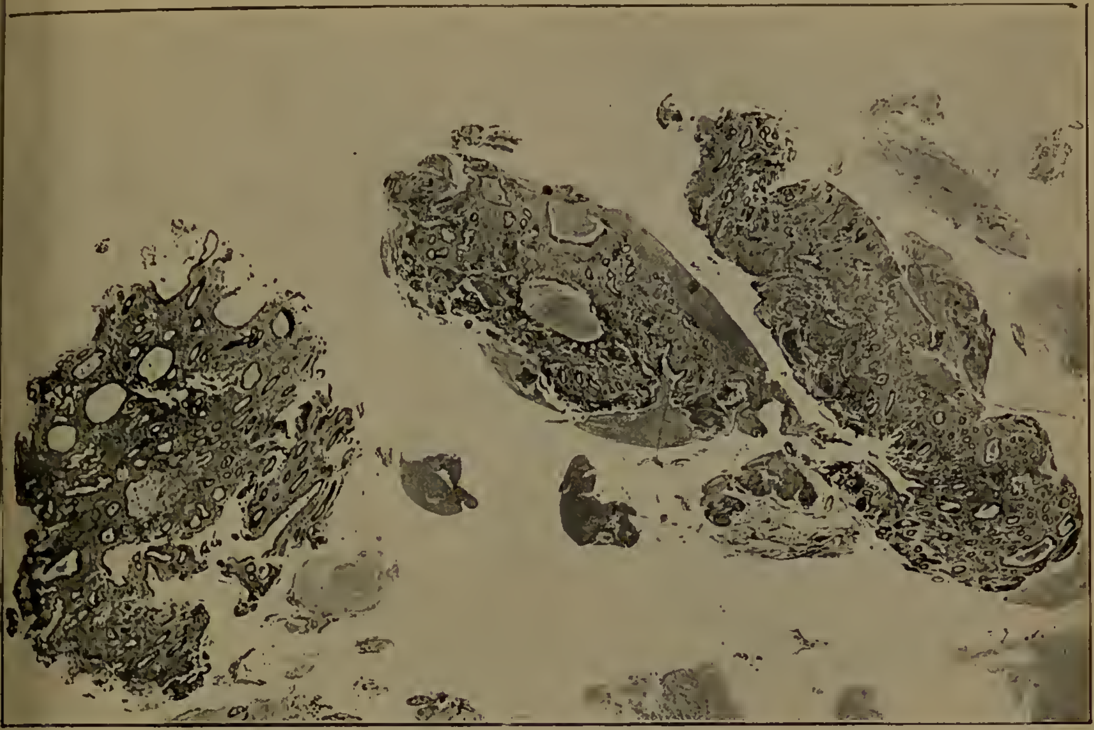
PLATE XVII.



Case II. (p. 309).—Sectional Drawing, showing Extent of Adhesions of the Sac Wall, Bladder, and Rectum.

[*To face p.* 309.

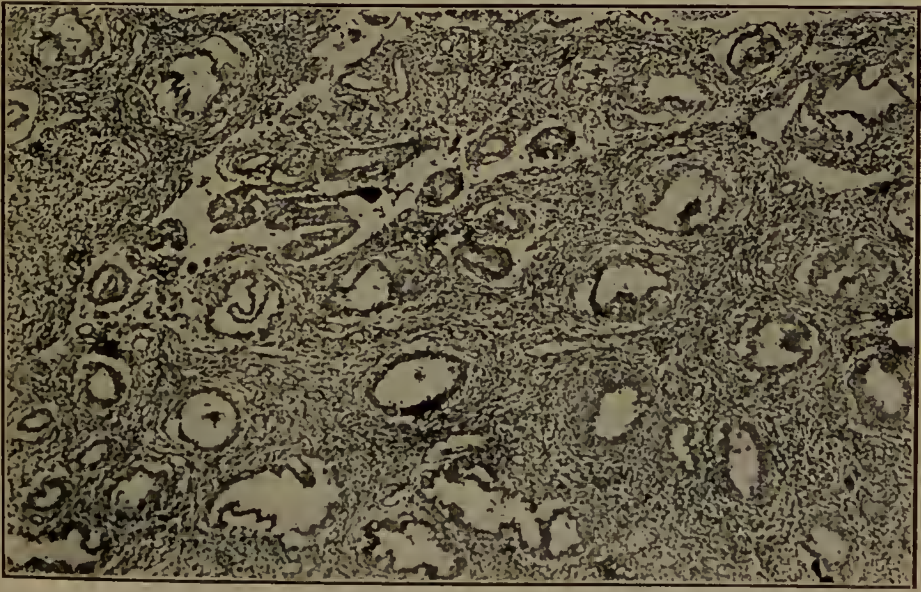
PLATE XVIII.



Curettings from a Case of Glandular Endometritis. (Author.)

Cystic degeneration in a case of hæmorrhagic endometritis. The tubules were distended into small cysts. There was also much round-celled infiltration of the stroma. [For sequel to this case, see plate over page.]

PLATE XIX.

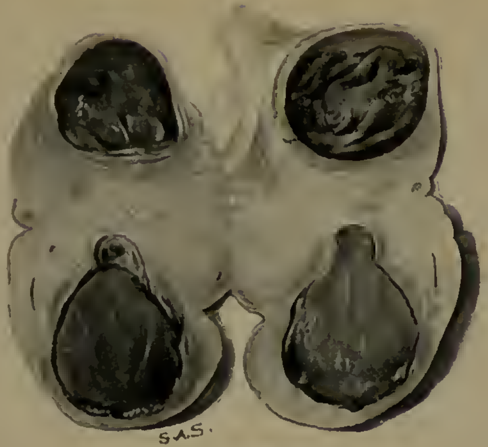


Portion of Curettings taken from a Case of Endometritis with Follicular Degeneration of the Cervix and Erosion. (Author.)

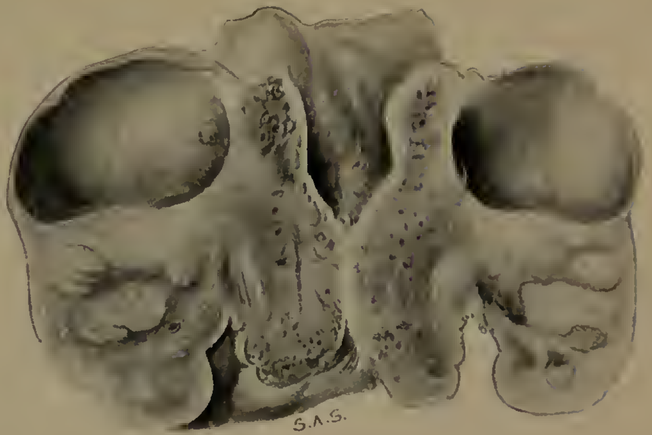
There is desquamation of the gland epithelium, with œdema of the subjacent muscle.

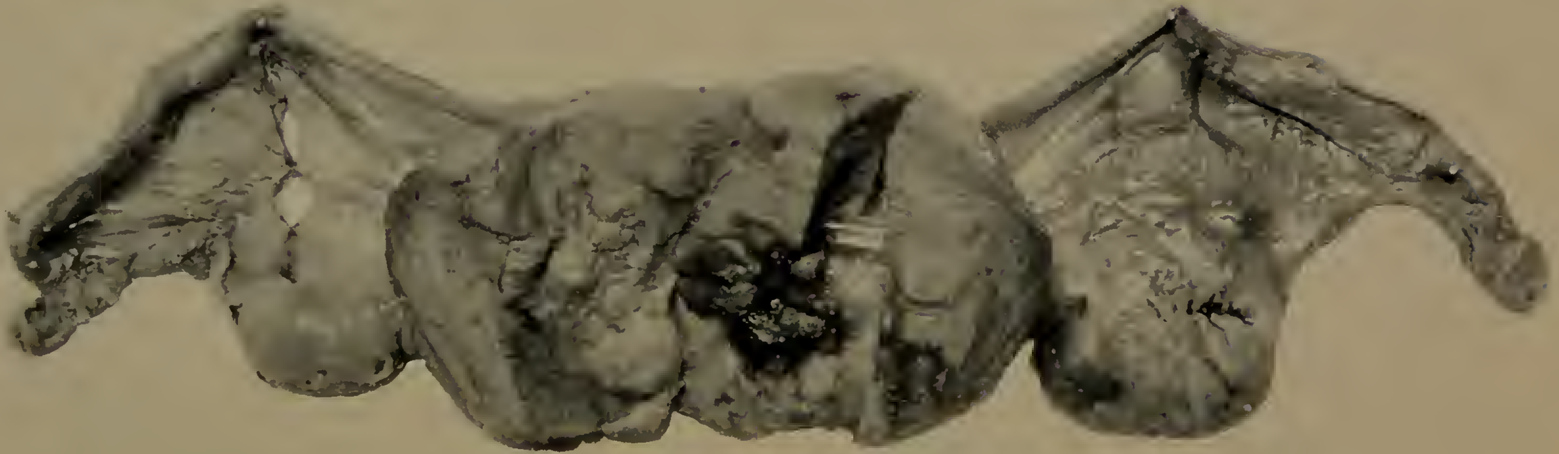
[*To face p.* 334.

PLATE XIXa.



(For the previous curetting
of the uterus, see Plate XVIII.)





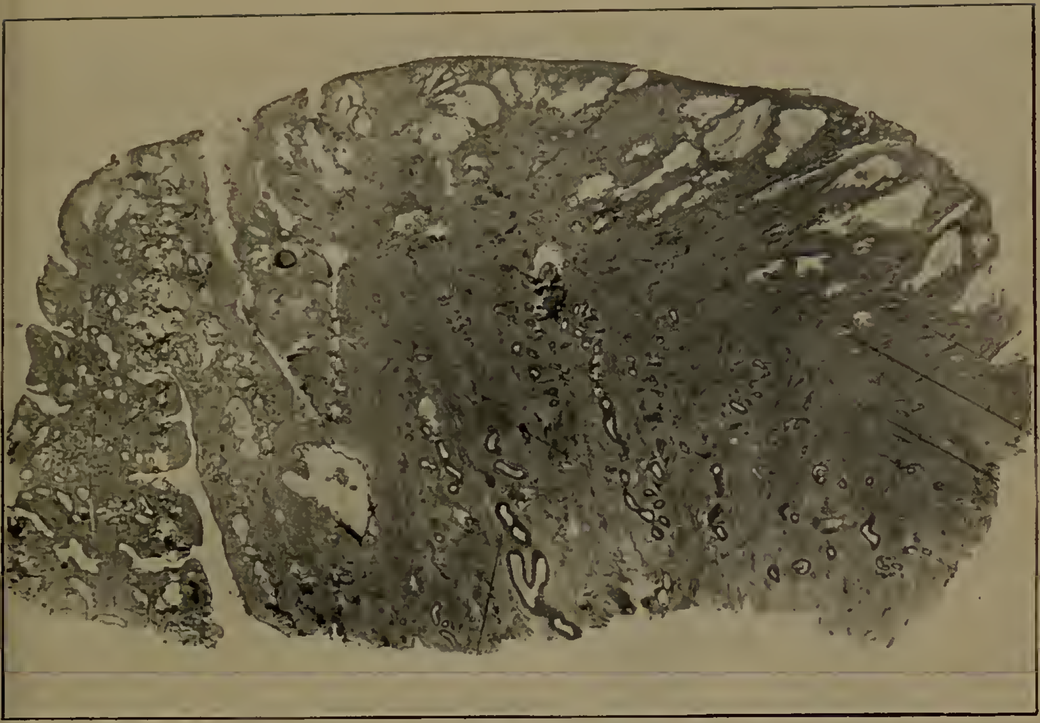
Drawings of the Ovaries and Photograph of the Uterus with Adnexa. Reduced $\frac{1}{3}$. (Author.)

Removed by supra-vaginal hysterectomy for hæmorrhagic endometritis in patient aged 49, twice previously curetted for hæmorrhage, from interstitial and glandular changes in the endometrium. The ovaries are bisected, showing two cysts in the left filled with blood coagula, and the solitary cyst in the right. (See opposite page.)

PLATE XIXa.—Sequel of Glandular Endometritis. (See Plate XVIII.)

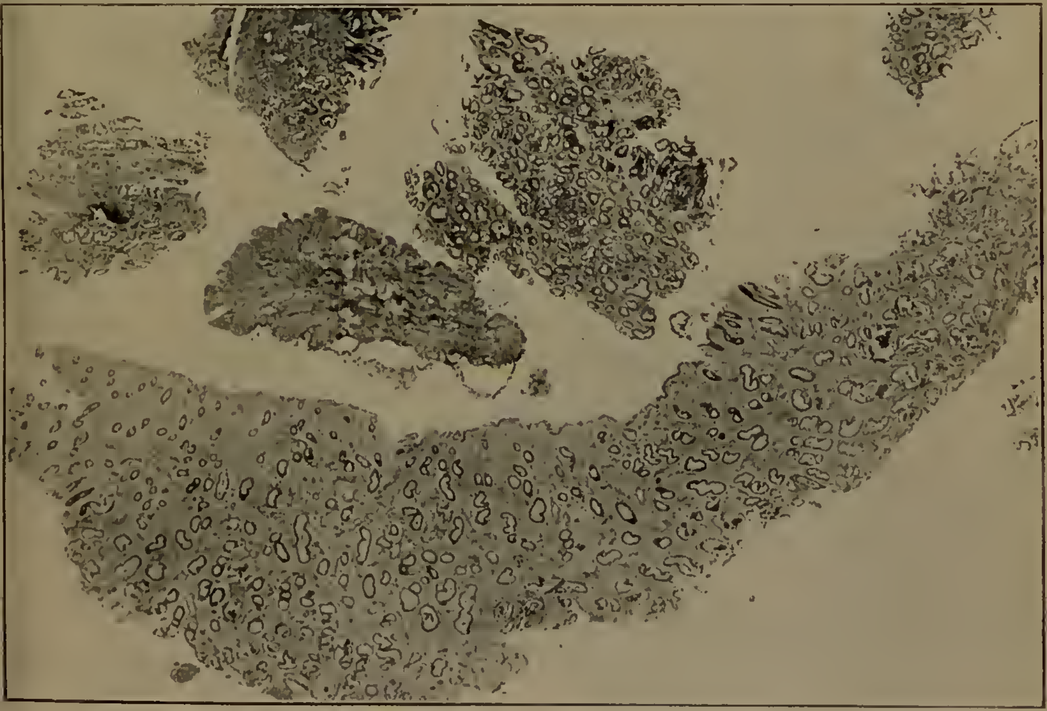
The patient, from whom this uterus and adnexa were removed, was aged 49, height 6 feet 1 inch. She had been twice curetted, and the uterine canal wiped out with chromic acid solution. Before each curettage she was blanched from hæmorrhage, and had a cardiac hæmic murmur, with feeble second sound. Each operation gave temporary relief. The bleeding recurring, I removed the uterus and adnexa by supra-vaginal hysterectomy. The examination of the specimen by Dr. Lockyer showed a thickened endometrium, covered by pultaceous deposit, consisting of epithelial débris. (When the uterus was divided after removal, a quantity of this pultaceous material, closely resembling muco-pus, exuded from the left cornu.) The excessive desquamation of the glands and the accumulation of epithelium explained the collection in the left cornu of this thick débris, not unlike pus. There was a small circular fibroid in the anterior wall. The tubes were slightly swollen and the fimbriæ œdematous. The left ovary contained two small blood cysts. The right had a thin-walled cyst at its inner pole. The patient is now in good health.

PLATE XX.



Transverse Section of One Half of the Portio in a Case of Severe Erosion and Cystic Degeneration of the Cervical Mucosa.

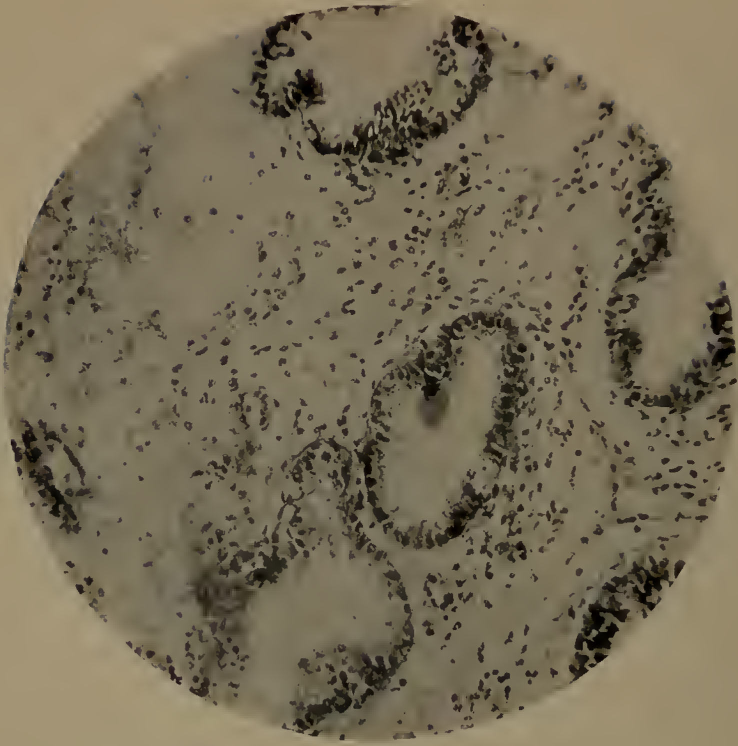
PLATE XXI.



Curettings of Glandular Endometritis—taken from same Case.

[*To face p.* 352.

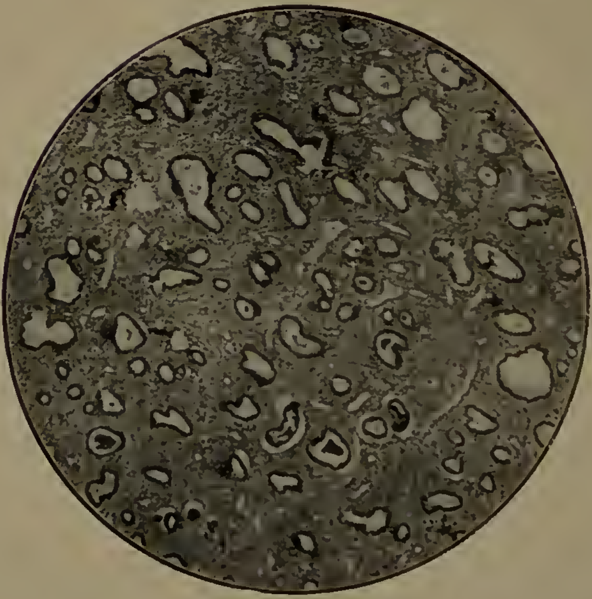
PLATE XXII.



Section from a Deep Erosion of the Cervix Uteri, associated with Glandular Endometritis.

($\frac{1}{6}$ objective.)

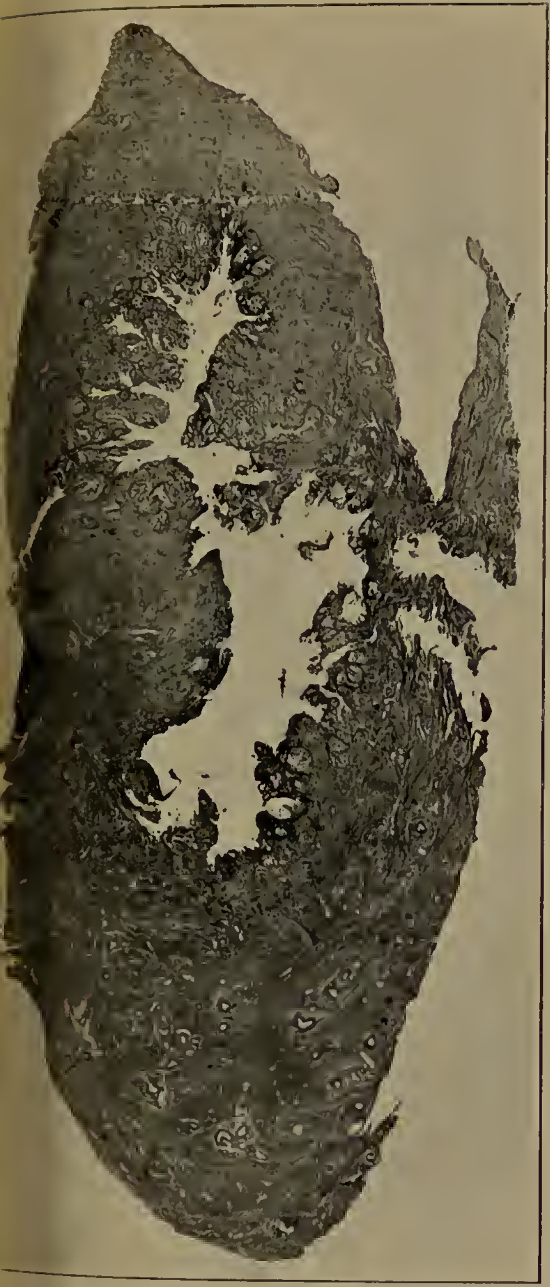
PLATE XXIII.



Curettings from a Case of Endometritis due to Gonococcus.

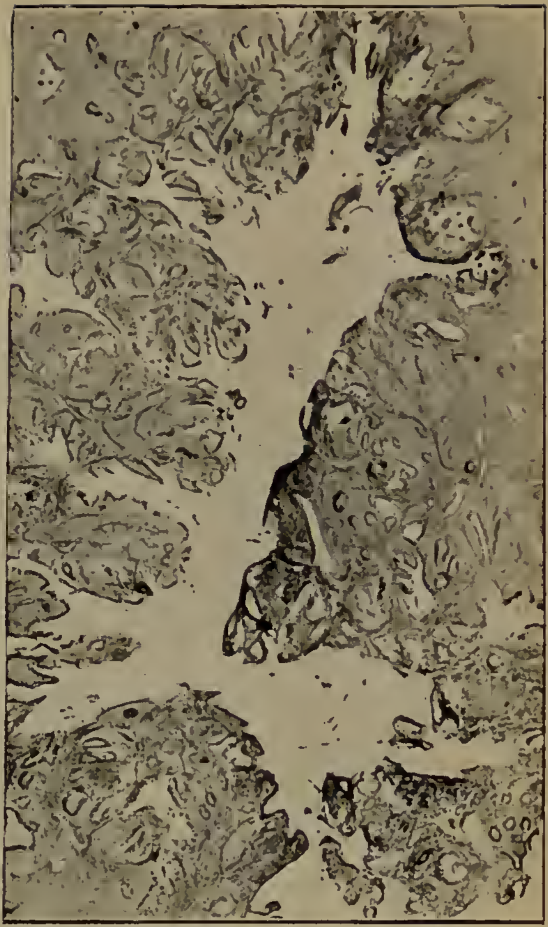
[*To face p.* 353.

PLATE XXIV.



ction of an Adenomyomatous Cervix, taken
rom an Eroded Surface. Enlarged 4½ Times.
Author.)

PLATE XXV.



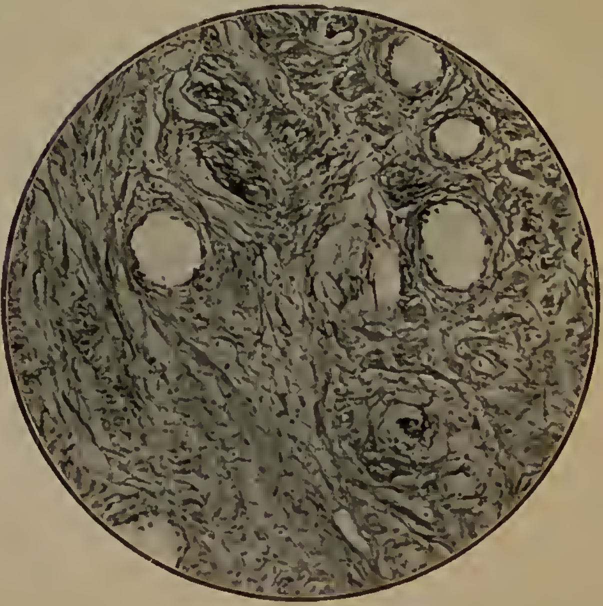
Portion of Central Cavity. Enlarged 20 Times.—This shaving of tissue was taken from a cervix which had been previously operated upon, leaving a granulated surface. Examination was made of a transverse section across the canal to determine malignancy. This area shows an open cleft with fimbriated margins; somewhat like a broken-down gland or abscess cavity.

PLATE XXVa.

A Section from close to Centre.

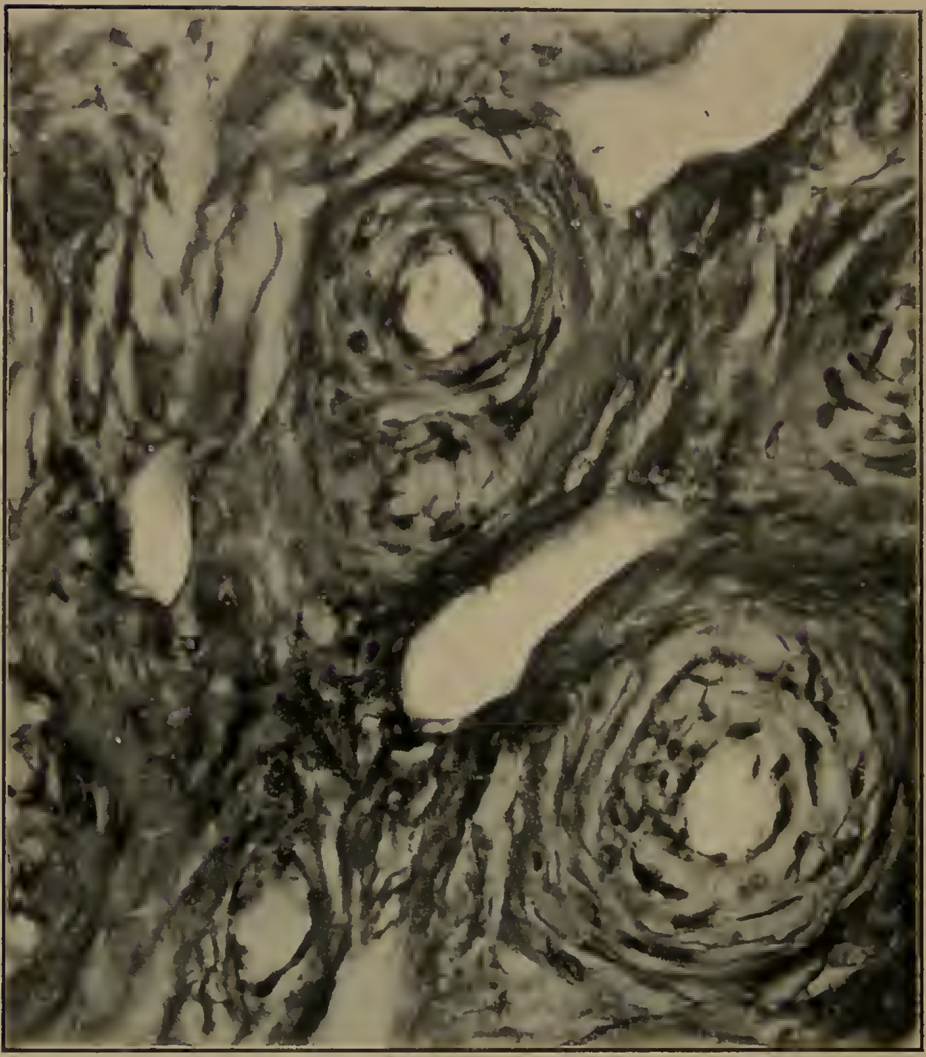
× 140.

See over page for microscopic report.



[To face p. 354.

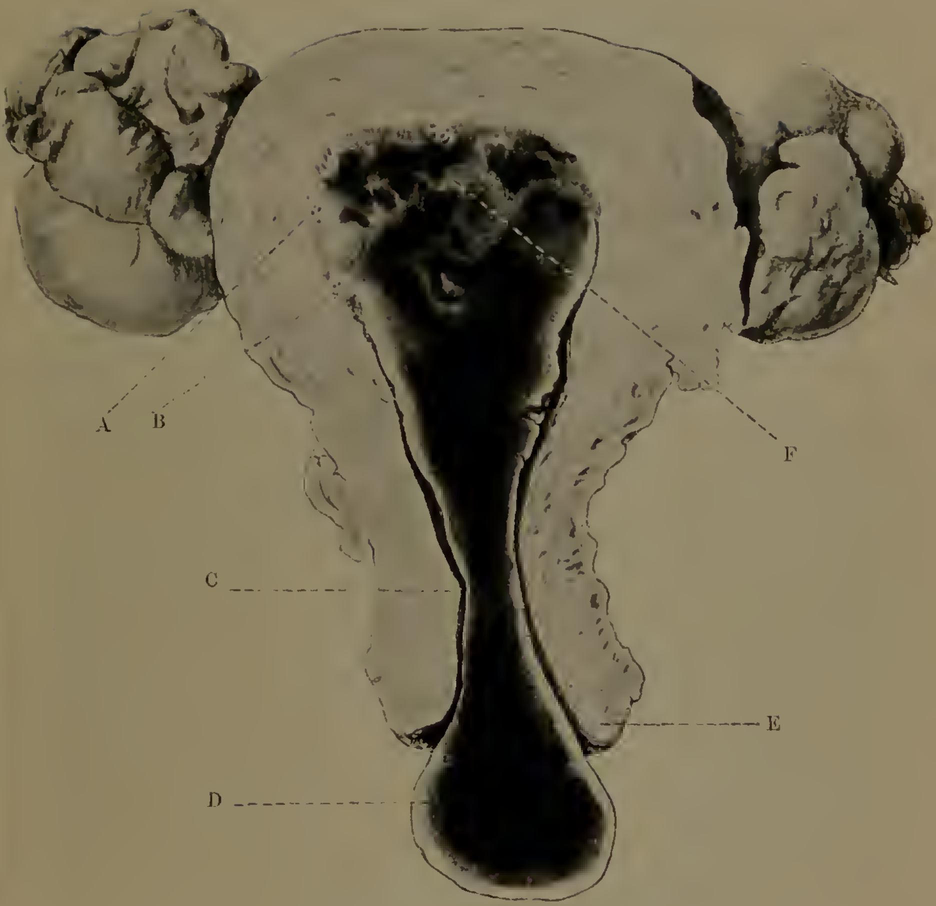
PLATE XXVB.



Report.—'Microscopically the central part consists of glandular tissue having a benign arrangement, *i.e.* the basement membrane of the various tubules is intact, but there is much degeneration and breaking down of the gland structure as a whole. The tubules trespass into the surrounding fibromuscular tissue, and the latter is characterized by its extreme vascularity. The numerous vessels all possess very thick walls; some are quite obliterated by the increase in thickness of the walls, having caused occlusion of their lumina. The specimen presents the features of an adenomyoma.' (× 500.)

[*To face p.* 355.

PLATE XXVII.

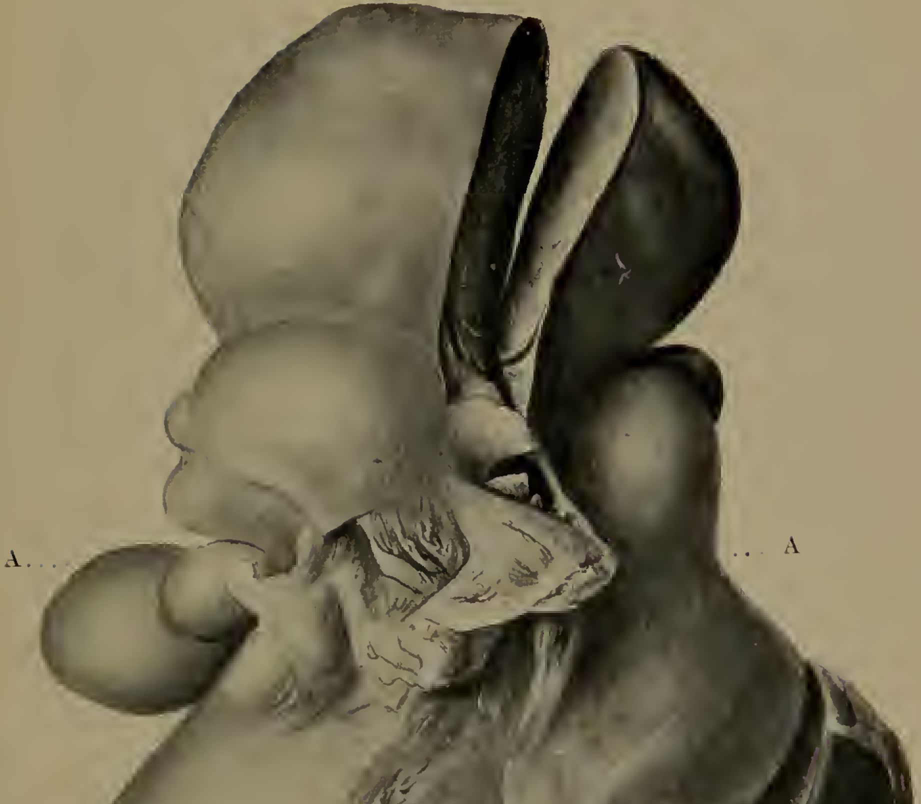


Placental Polypus. (Bumm.)

Prep. in Frauenklinik in Basil. A, B, utero-placental arteries; C, E, internal and external os; D, polypus projecting from uterus; F, placental attachment with blood coagula.

[*To face p.* 392.

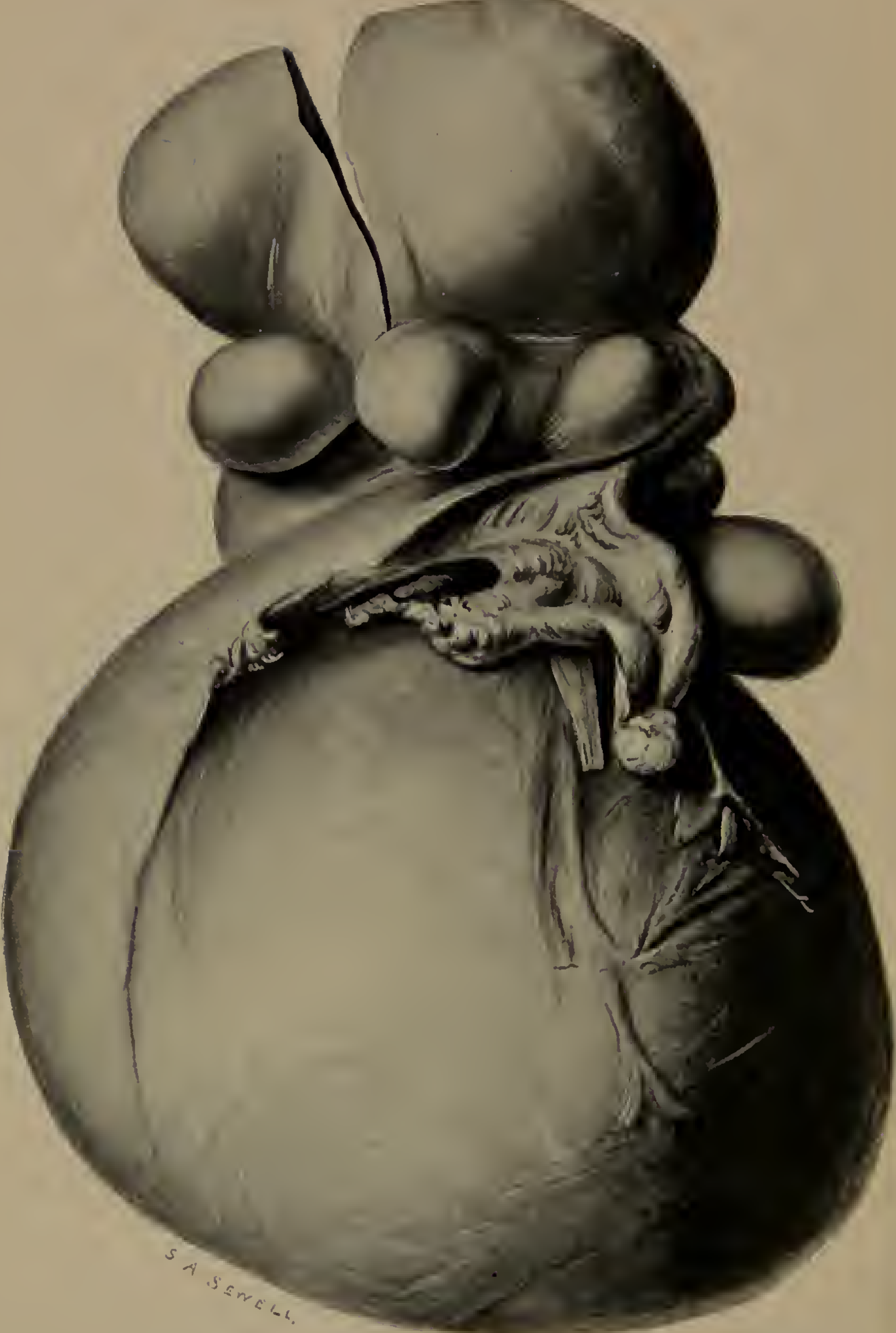
PLATE XXVIII.



Giant Multiple Myoma. (Author.)

Reduced to less than half-size. Dotted line A, A, marks the upper border of the abdominal portion. The mass above the line pushed up the diaphragm at the left side, causing dyspnœa and tachycardia. This was not discerned until operation. The lower mass filled the abdomen. Removed by supravaginal hysterectomy. [*To face p.* 402.

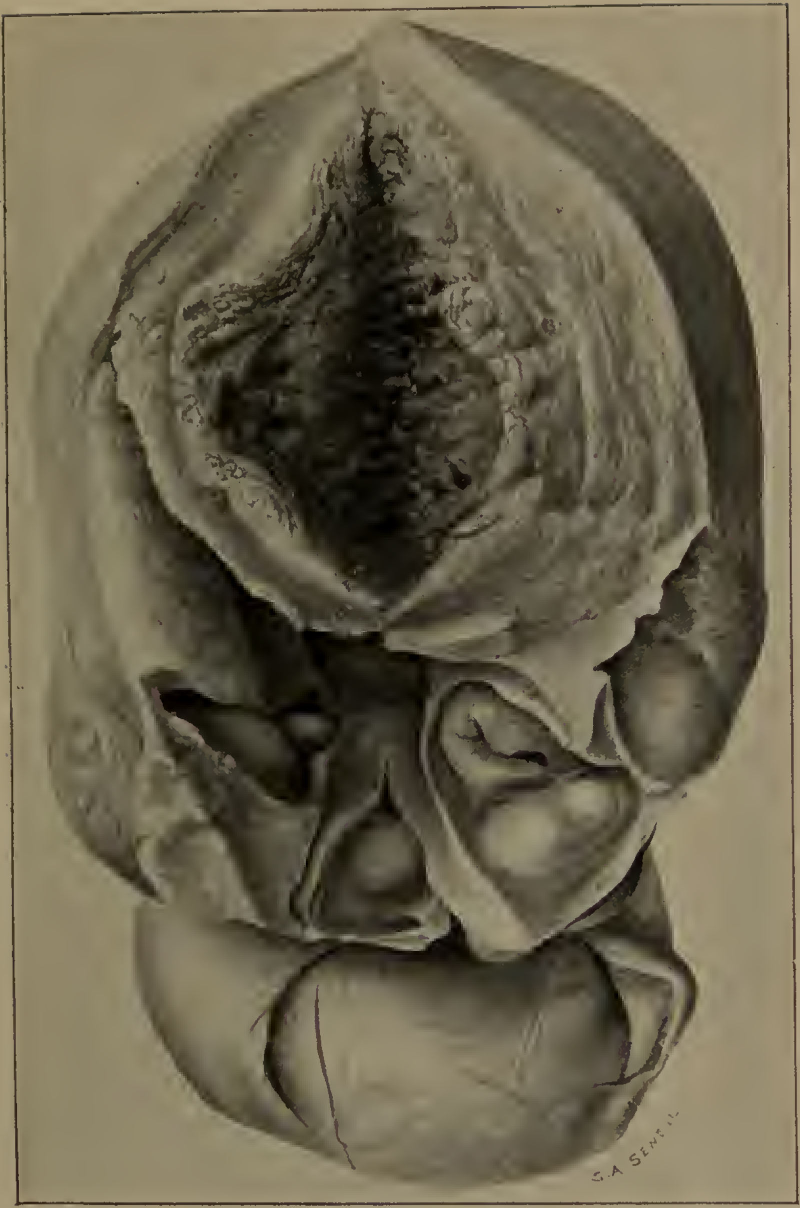
PLATE XXIX.



Posterior Surface of same Tumour. (Author.)

[*To face p.* 403.

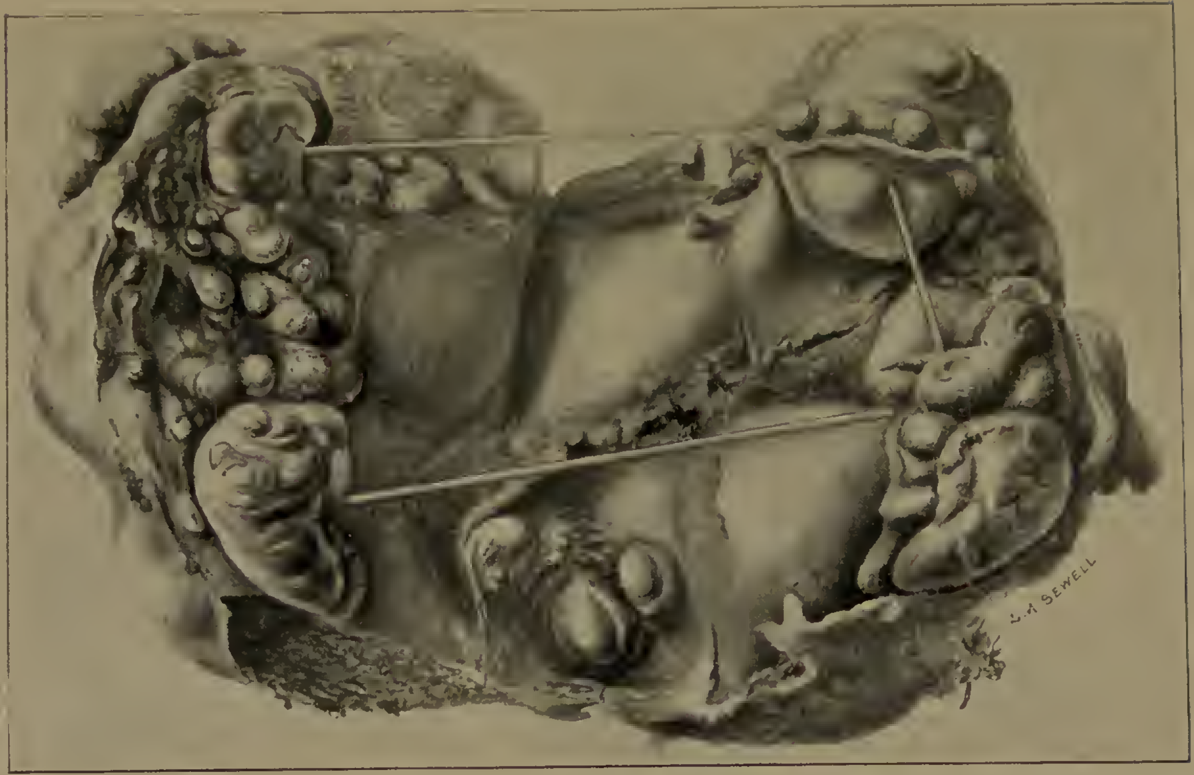
PLATE XXX.



DUAL MYOMA OF THE UTERUS—NECROBIOSIS AND MUCOID WITH CALCAREOUS DEGENERATION. (AUTHOR.)

There were no urgent symptoms. The patient was otherwise in good health, but the tumour was perceptibly increasing in size. Operation was decided upon, and supra-vaginal hysterectomy performed. On section, a considerable necrotic area was found in the upper myoma bounded by a zone of calcareous degeneration, and the canal of the uterus greatly enlarged and full of mucoid fluid. [*To face p.* 410.

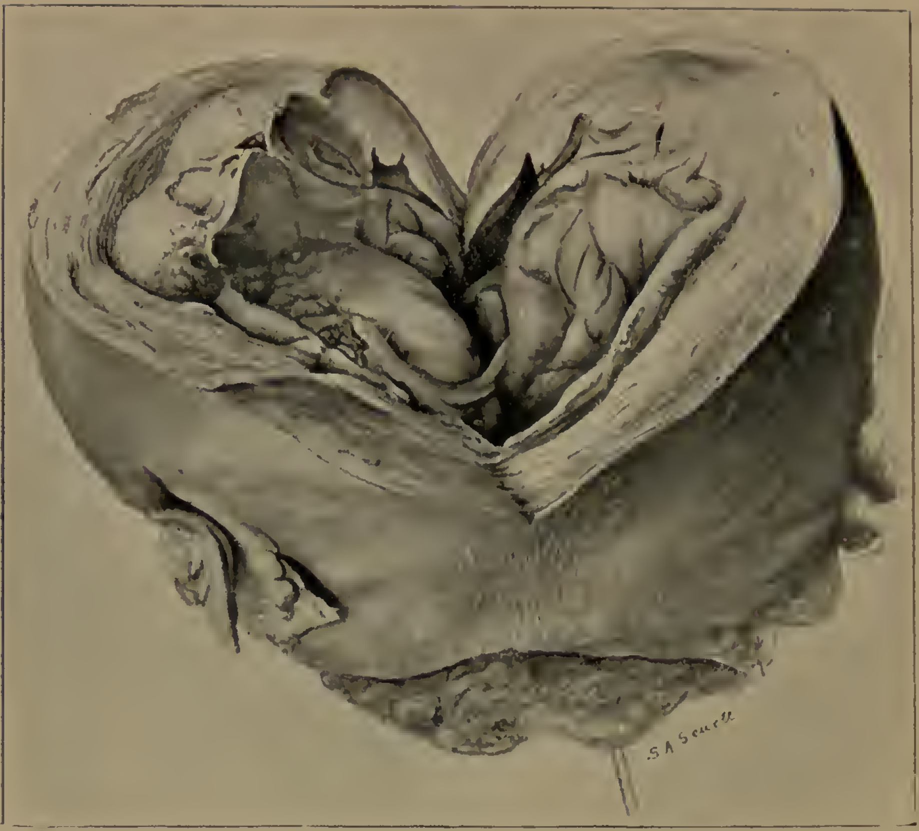
PLATE XXXI.



Large Multiple Myoma ($\frac{1}{3}$ natural size) removed from Patient, aged 54, suffering from Profound Anæmia caused by Violent Hæmorrhage during the Climacteric Supra-vaginal Hysterectomy. (Author.)

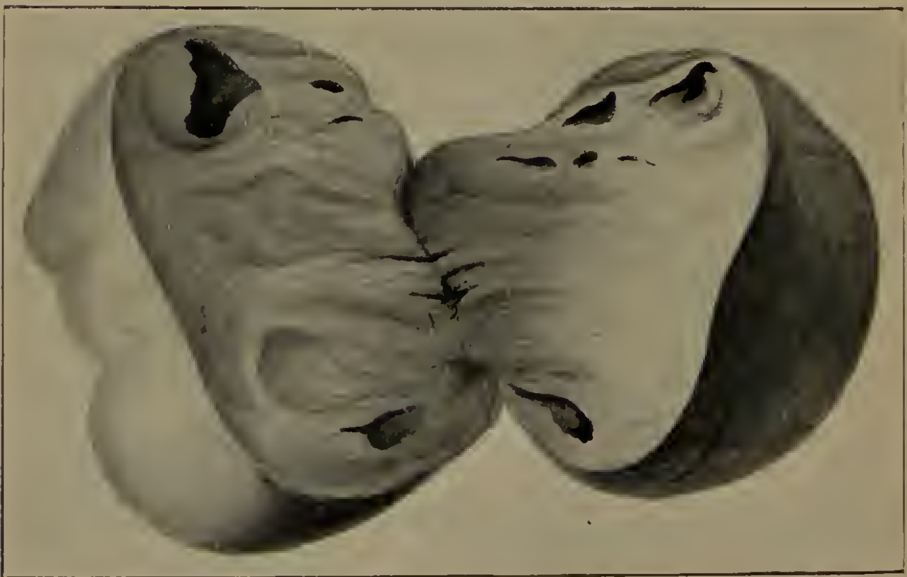
There was a large central cavity filled with mucoid fluid. Recovery. [*To face p.* 412.

PLATE XXXII.



Cysto-sarcoma of the Uterus, with Associated Necrobiotic and Mucoid Degeneration surrounded by the Muscular Structure of the Uterus. (W. B. Jessett.)

PLATE XXXIII.

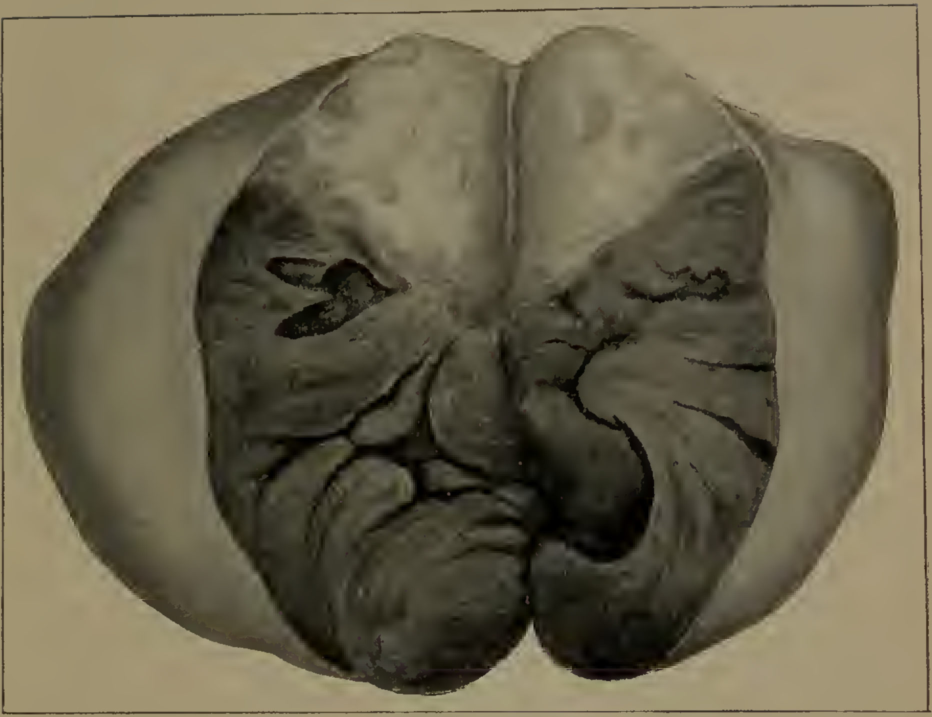


Subserous Fibroid of Uterus with Myxomatous Degeneration. (Author.)

The entire substance of the tumour was converted into myxomatous tissue, with cavities here and there filled with mucoid fluid.

[*To face p.* 413.

PLATE XXXIV.



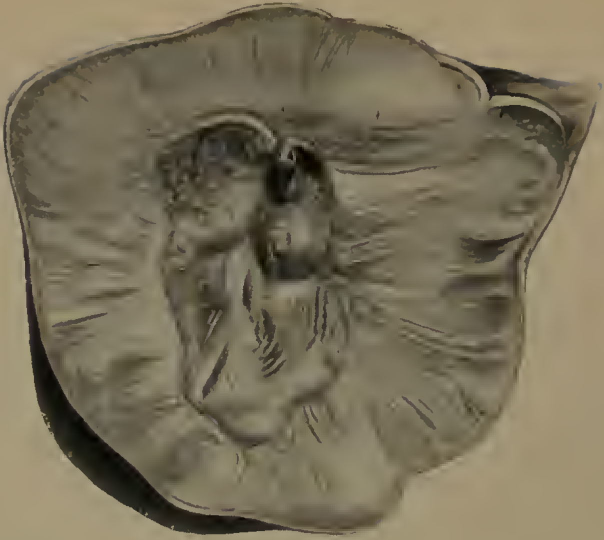
Telangiectatic Myoma. (Purefoy.)

Patient, aged 52, unmarried; had severe attack of peritonitis, lasting 6 weeks; large abdominal tumour discovered while under treatment; was operated upon at the Rotunda Hospital. There were numerous omental adhesions, the separation of which caused much hæmorrhage. The abdominal wall was firmly incorporated with the anterior surface of a large fibroid, connected with the left cornu of the uterus by a small pedicle.

On section, the substance of the tumour, except a small portion near the pedicle, was found to be of a dark red colour, and was hollowed out into large cavities freely communicating and containing unaltered blood in large quantities. Dr. Earle reported as follows on the microscopical appearances:—'The tissues of the tumour, though so unusual in colour, did not show degenerative changes, but stained in the usual way, and the numerous cavities having a very smooth lining membrane appeared to be dilated bloodvessels.' This condition in a myoma is of great rarity, and very few instances of it have as yet been reported in this country.

[*To face p.* 414.

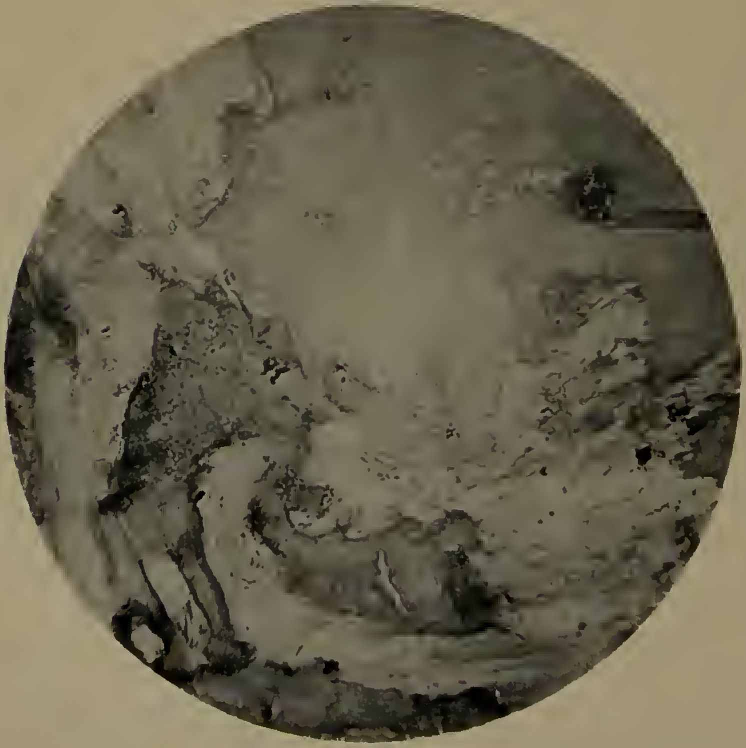
PLATE XXXV.



Section of Portion of Myoma, showing Central Area of Calcification, the Result of Hyaline Degeneration.

The tumour removed by myo-hysterectomy, showed in section a central area of calcification, in the centre of which was a small calcified mass. Within a hyaline patch some thick-walled vessels containing organized blood-clot are seen. A hard nodule from another part of the growth has been decalcified and examined. It shows that the calcareous deposit has been laid down in parts of the fibroid which have previously undergone the hyaline change above referred to. Such hyaline degeneration is likewise associated with the calcification present in some forms of carcinoma.

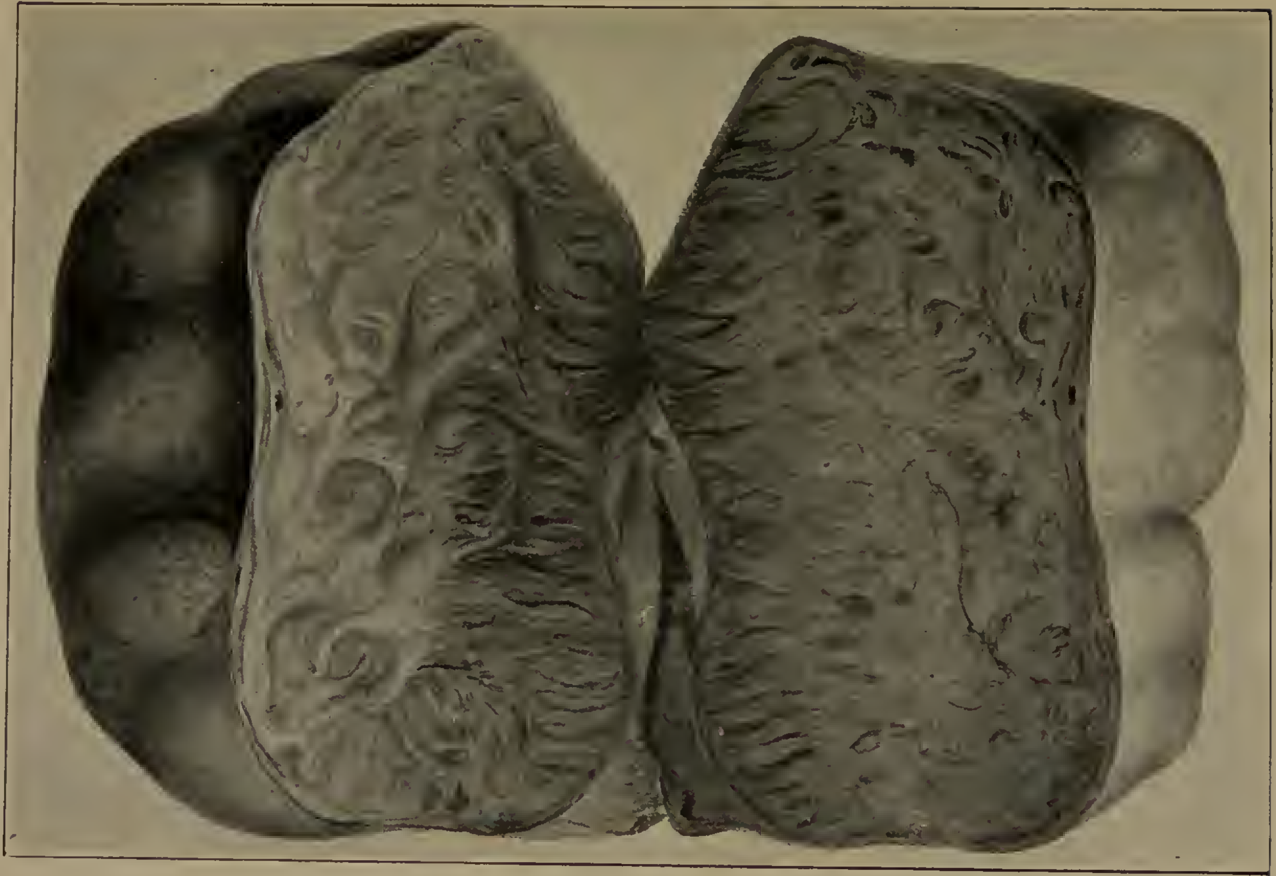
PLATE XXXVI.



Area of Hyaline Degeneration, with Process of Calcification Proceeding.

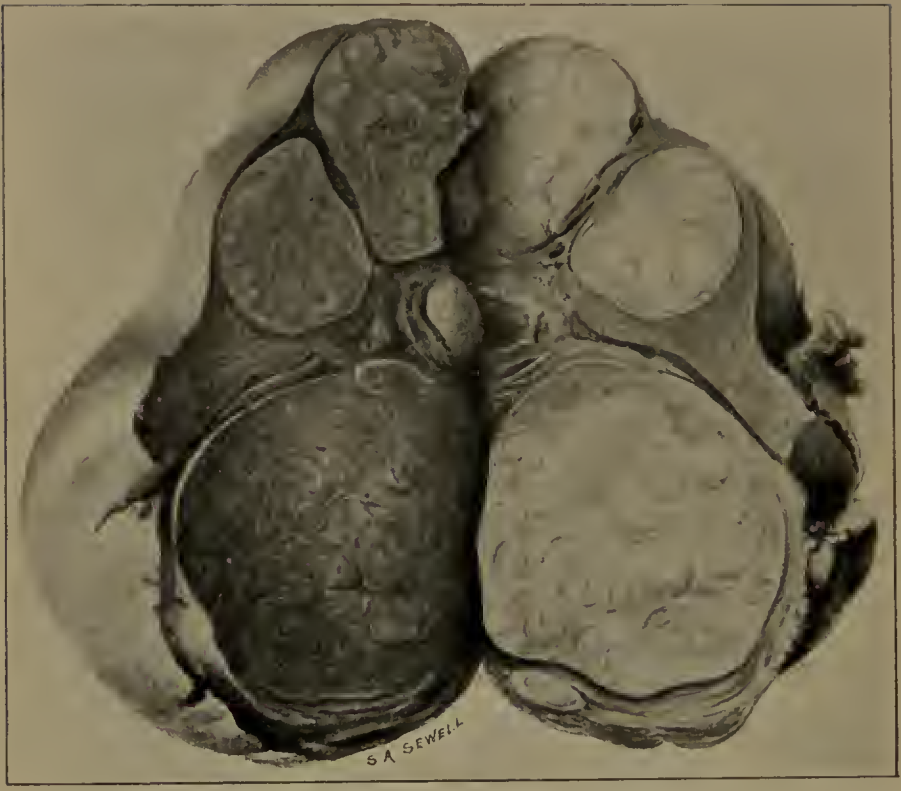
[*To face p.* 115.

PLATE XXXVII.



Large Intramural Myoma of the Uterus, showing its Reticulated Structure removed by Supra-vaginal Hysterectomy. (Author.) [*To face p.* 426.

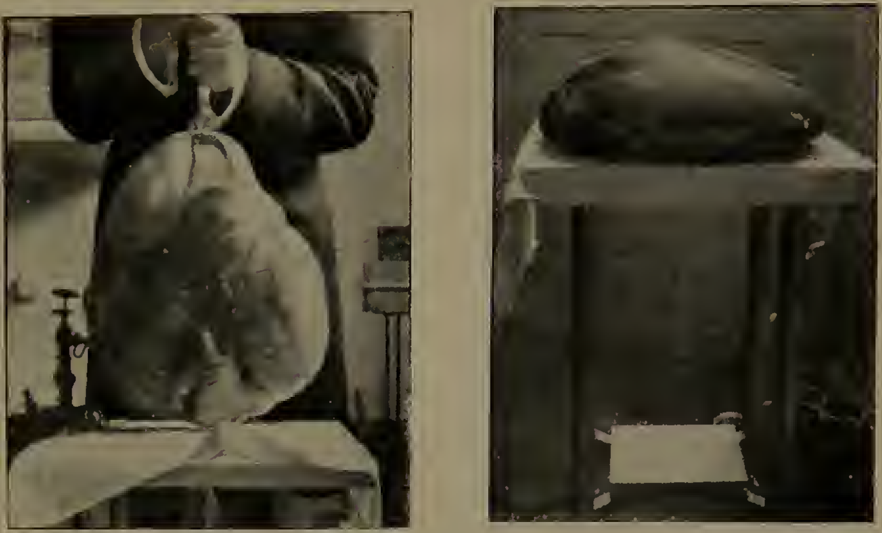
PLATE XXXVIII.



Uterine Myoma with Embedded Multiple Nuclei removed at the Climacteric by Supra-vaginal Hysterectomy. (Author.)

[*To face p.* 427.

PLATE XXXIX.

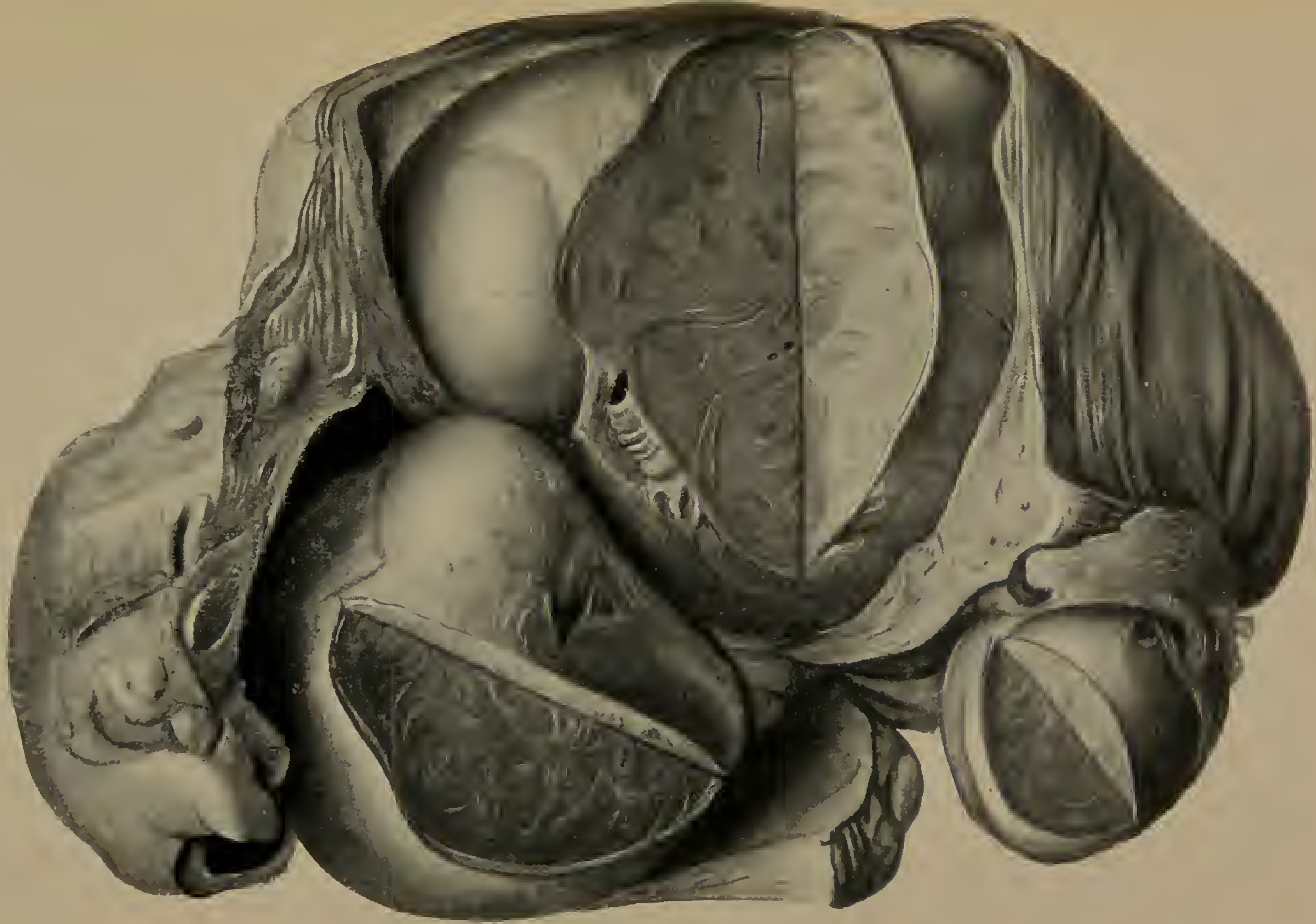


GIANT FIBROMYOMA.

The patient from whom the tumour was removed was a multipara, aged 50. Her last pregnancy occurred eleven years previously. She had never suffered any particular pain, and could not date the commencement of the growth, which she had only noticed some two years before I saw her in 1898, and only within the last few months had there been a rapid increase in size. The periods had been irregular in occurrence and quantity, and there was a considerable loss a few days before operation. On examination a large movable abdominal tumour was found, semi-solid to the touch, and associated with the uterus, the cavity of which was over five inches in length. The abdomen was enlarged much beyond the size of the full term of pregnancy. The patient was fully aware of the risk connected with the operation. The enormous tumour was found to be free from adhesions, and was delivered through an incision reaching from below the ensiform cartilage to the pubes. A broad pedicle attached it to the left broad ligament, and there was a separate attachment to the uterus. The capsule having been completely detached by a circular incision and stripped down, the attachment to the uterus was secured and supra-vaginal hysterectomy completed. The large broad ligament pedicle was then ligatured in segments and the tumour was detached. After removal it was found that the bladder had been opened. The wound was closed by catgut sutures and a catheter was retained. The operation lasted altogether two hours, and during the last half-hour sub-cutaneous (sub-mammary) injections of artificial serum were maintained. The anæsthetic given was chloroform. There was dangerous collapse on the delivery of the tumour, and again towards the close of the operation. As there was some bleeding from the bladder, it was washed out at intervals with a solution containing 30 minims of liquid extract of suprarenal capsule. The tumour proved to be a solid fibromyoma, and it weighed 28½ pounds. Its size and shape can be estimated from the accompanying illustrations taken from photographs (Plate XXXIX.). The table on which the tumour rests measures 16 × 16 inches. (The uterus and adnexa are not shown.) The patient is in excellent health.

[To face p. 446.

PLATE XL.

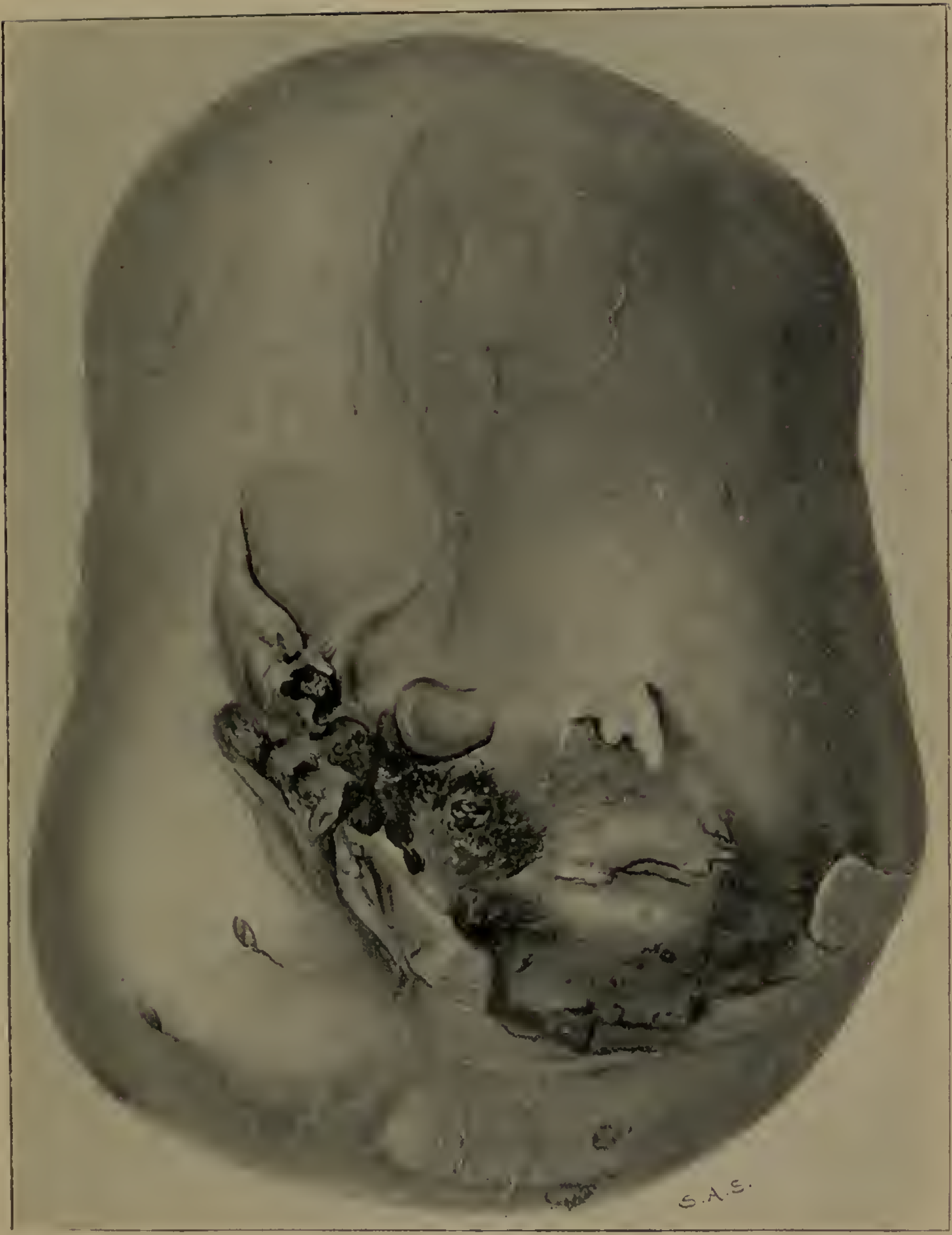


MULTIPLE MYOMA, SHOWING ENCAPSULED NUCLEI,-IN A PATIENT AGED 55, AFTER TWO ATTACKS OF PERITONITIS.

Removed by supra-vaginal hysterectomy. Patient had a severe attack of cellulitis, rising almost to level of umbilicus in the third week after operation. Opening made through right inguinal region; slough and pus evacuated: drainage. Recovery.

[*To face p.* 447.

PLATE XLI.

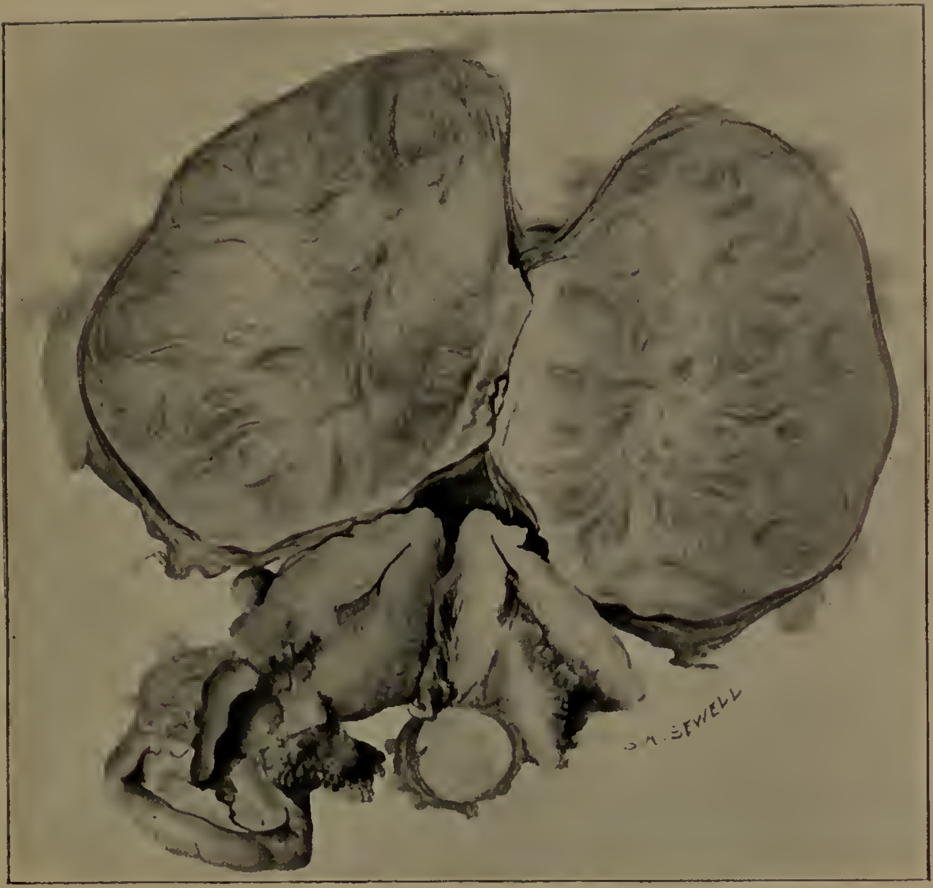


Large Dense Fibroma, of Stony Hardness, filling the Pelvic Cavity, and fixed by Adhesions to the Rectum and Floor of the Pelvis. (Author.)

(Case referred to p. 453.)

[*To face p.* 453.

PLATE XLII.

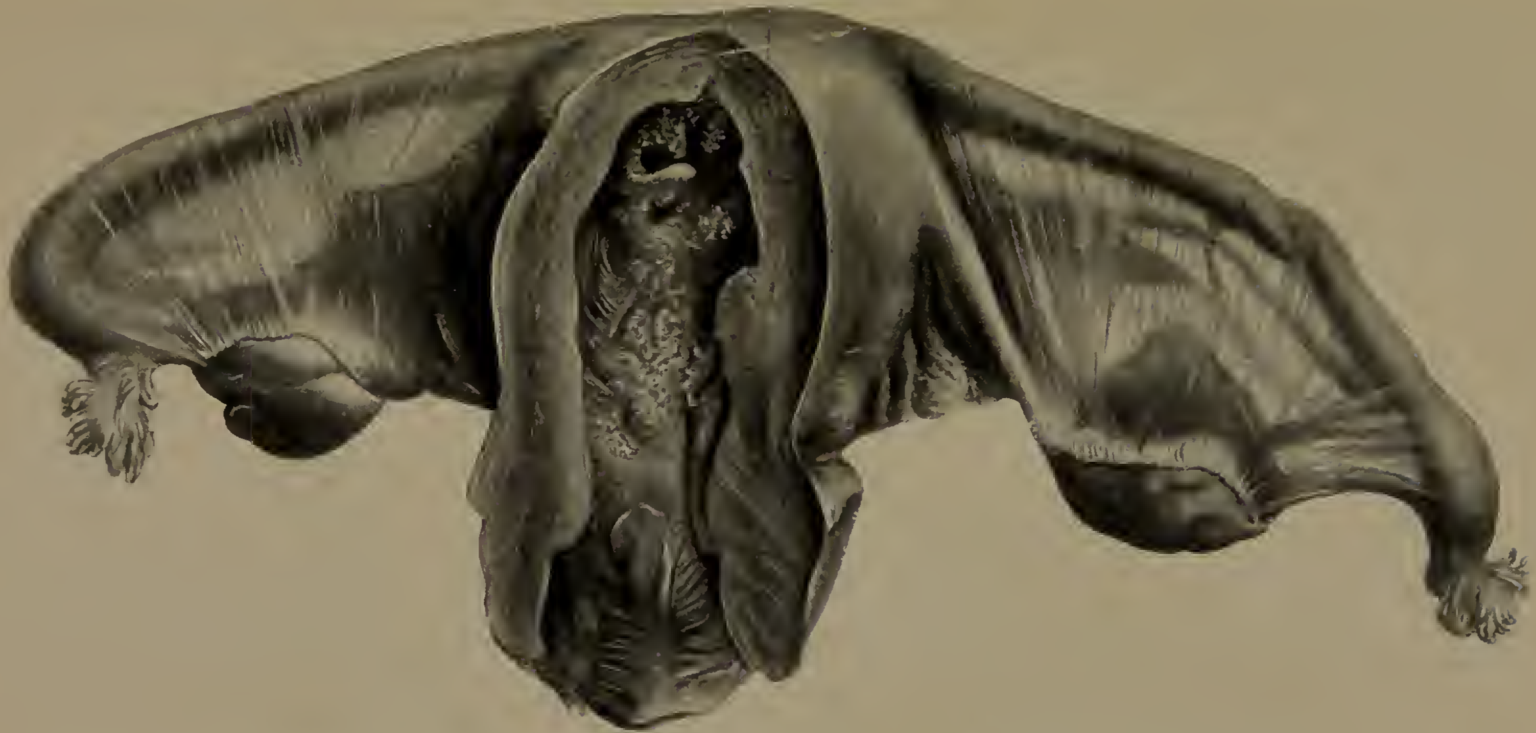


Myoma complicated with Carcinoma. (Author.)

The fibro-myoma was the size of a fœtal skull at term. It was removed from a spinster, aged 58, by vaginal hysterectomy. *Pathological Report:* The specimen consisted of three portions; the largest was an oval intramural fibroid, 5 ins. in its chief diameter, projecting from the back of the uterus near the fundus. The lower segment of the uterus was invaded by a soft white growth, a columnar-celled carcinoma, with solid branching columns of epithelium. Below this was a small fibroid distinct from the carcinomatous portion, and not infiltrated by it. The third part consisted of the cervix uteri, and adjacent portions of the vagina. The os uteri, the internal surface of the cervix uteri, as far as the internal os, were normal, though there was much inflammatory infiltration between the bundles of muscle fibres. The patient made a good recovery from the operation, survived twelve months, and died, as I learned, from some acute attack of bowel obstruction, doubtless of a malignant nature. (See pp. 406 *et seq.*)

[*To face p.* 570.

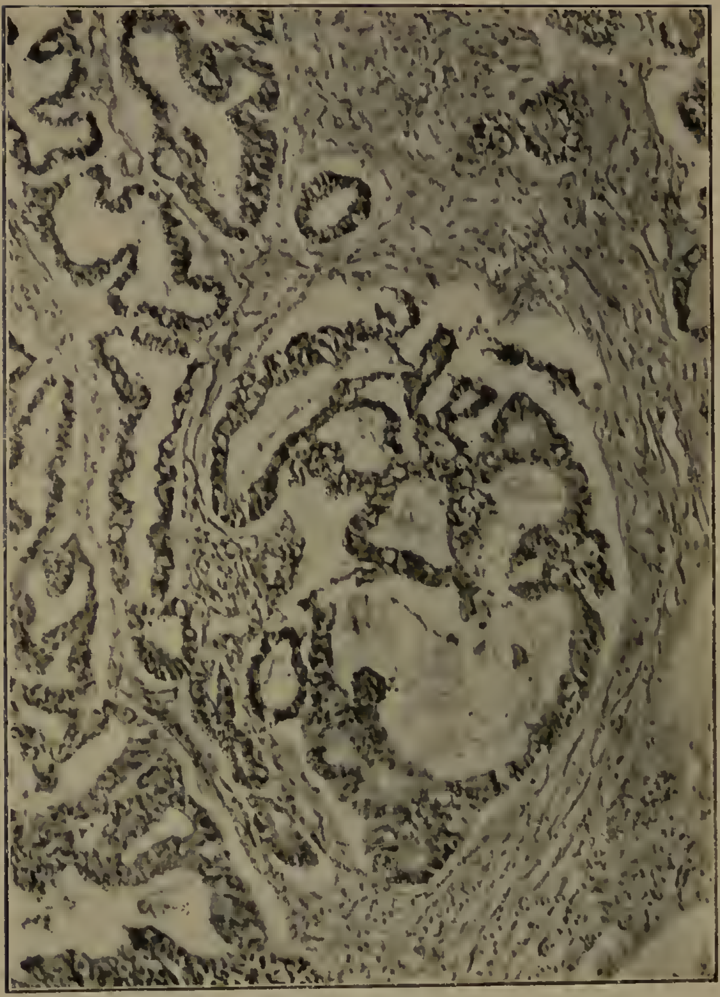
PLATE XLIII.



Cancer of the Fundus—Cervix Free from Disease—Uterus and Adnexa removed by Author by Bumm's Operation.

[*To face p.* 572.

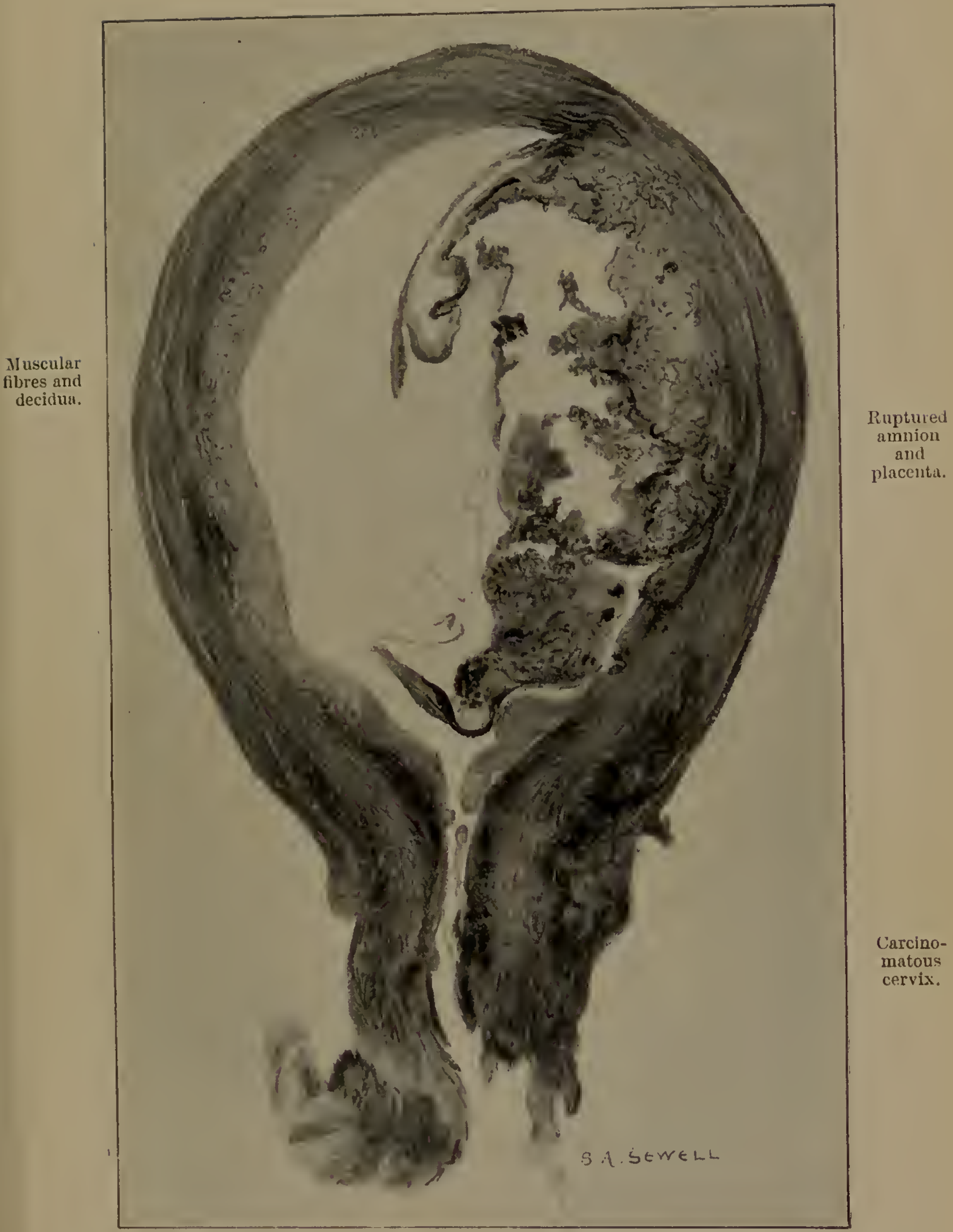
PLATE XLIV.



Currettings from Fundus removed before Operation.

[*To face p.* 573.

PLATE XLV.

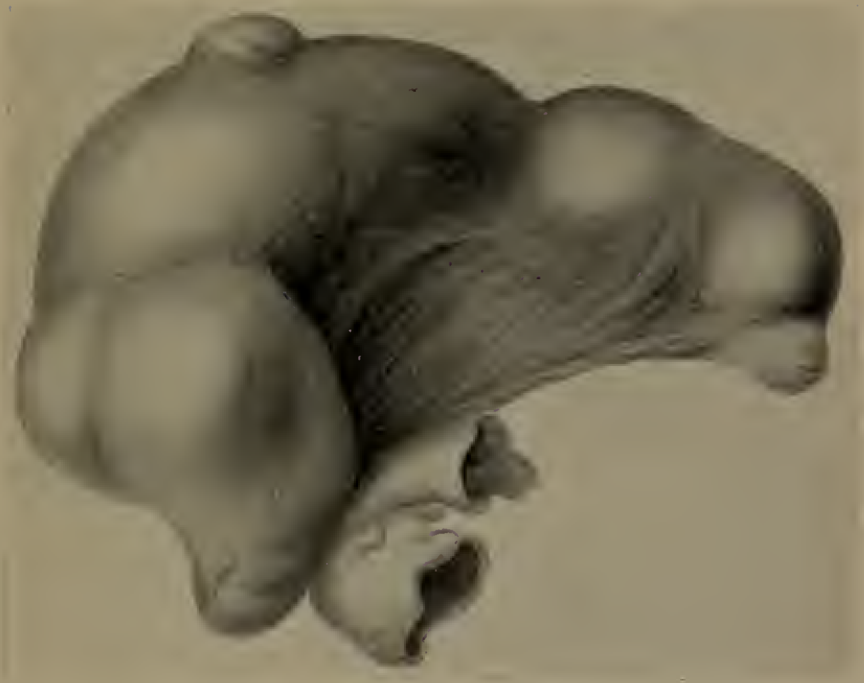


SECTION OF UTERUS (NATURAL SIZE) AT END OF THE THIRD MONTH OF PREGNANCY WITH CARCINOMATOUS CERVIX, SHOWING DECIDUA AND RUPTURED AMNION. OPERATION VAGINAL HYSTERECTOMY.

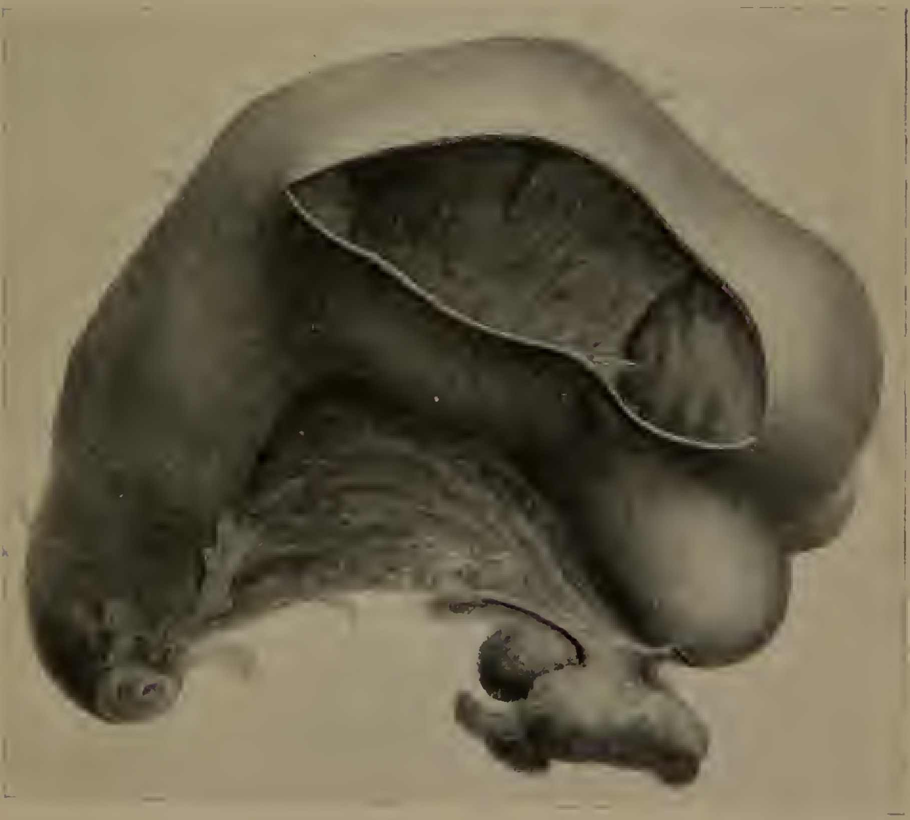
The section was made in Halle when the author was there, and given him by Professor Bumm.

[*To face p.* 600.

PLATE XLVIII.



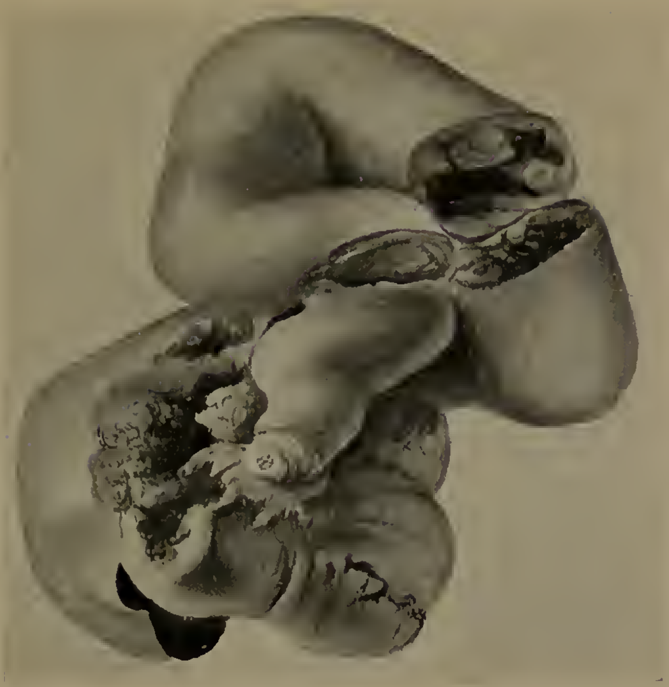
PRIMARY TUBERCULOSIS OF THE FALLOPIAN TUBE—PYO-SALPINX.



SAME—SAC OPENED FROM BEHIND.

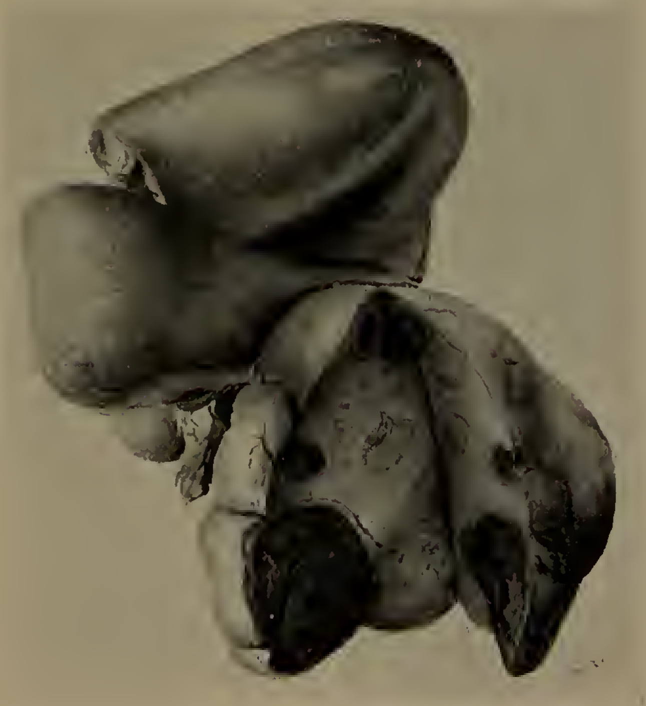
[*To face p.* 641.

PLATE XLIX.



ADNEXA, SHOWING SECTION OF THE DILATED TUBE AND THE CONTAINED BLOOD COAGULUM; ALSO THE ADHERENT FIMBRIA. (AUTHOR.)

Tuberculosis of the Fallopian Tube (seen from above and in front).

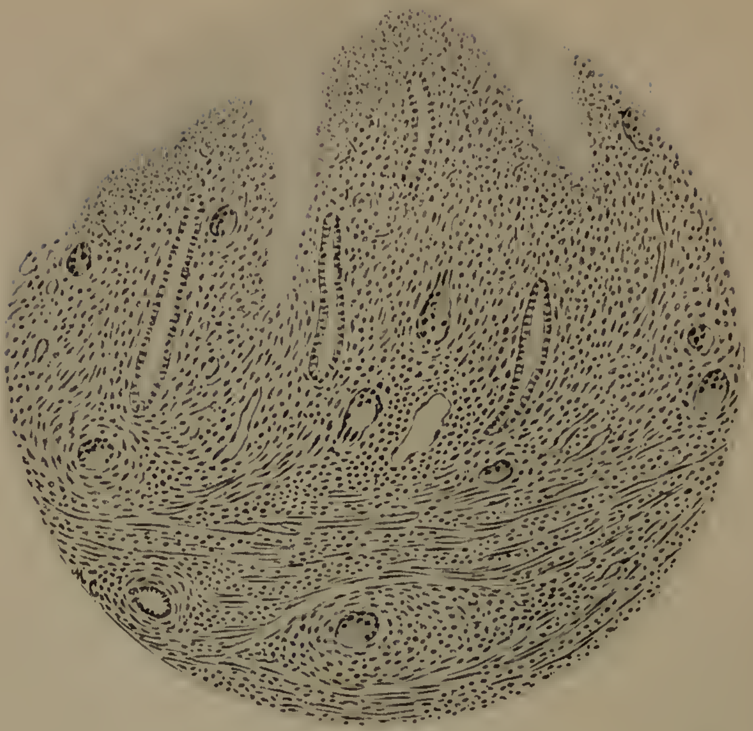


SAME SPECIMEN, SHOWING THE OVARY CUT OPEN AND THE RECENT CORPUS LUTEUM. (AUTHOR.)

Tuberculosis of the Fallopian Tube (seen from behind).

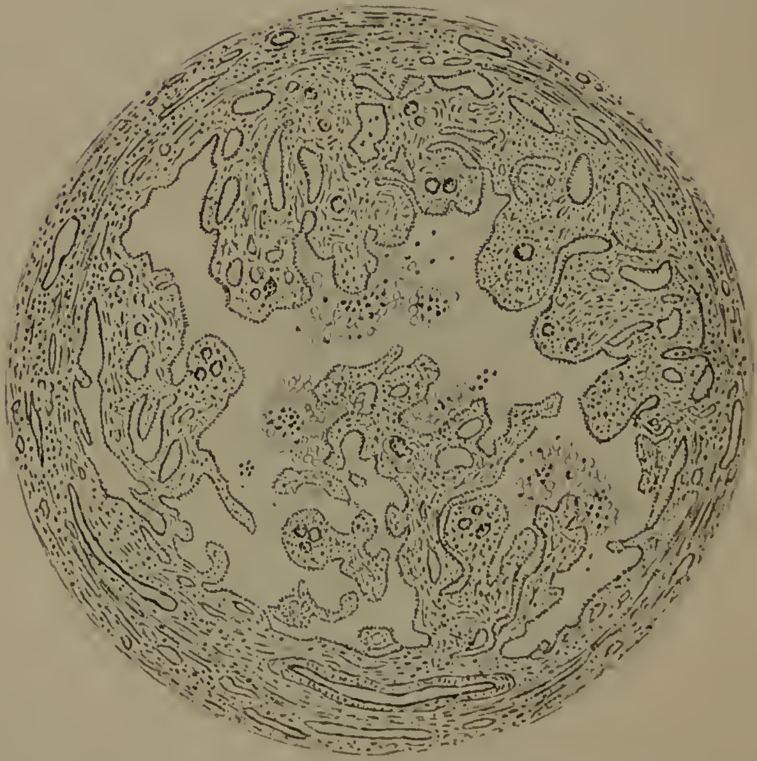
[*To face p.* 642.

PLATE L.



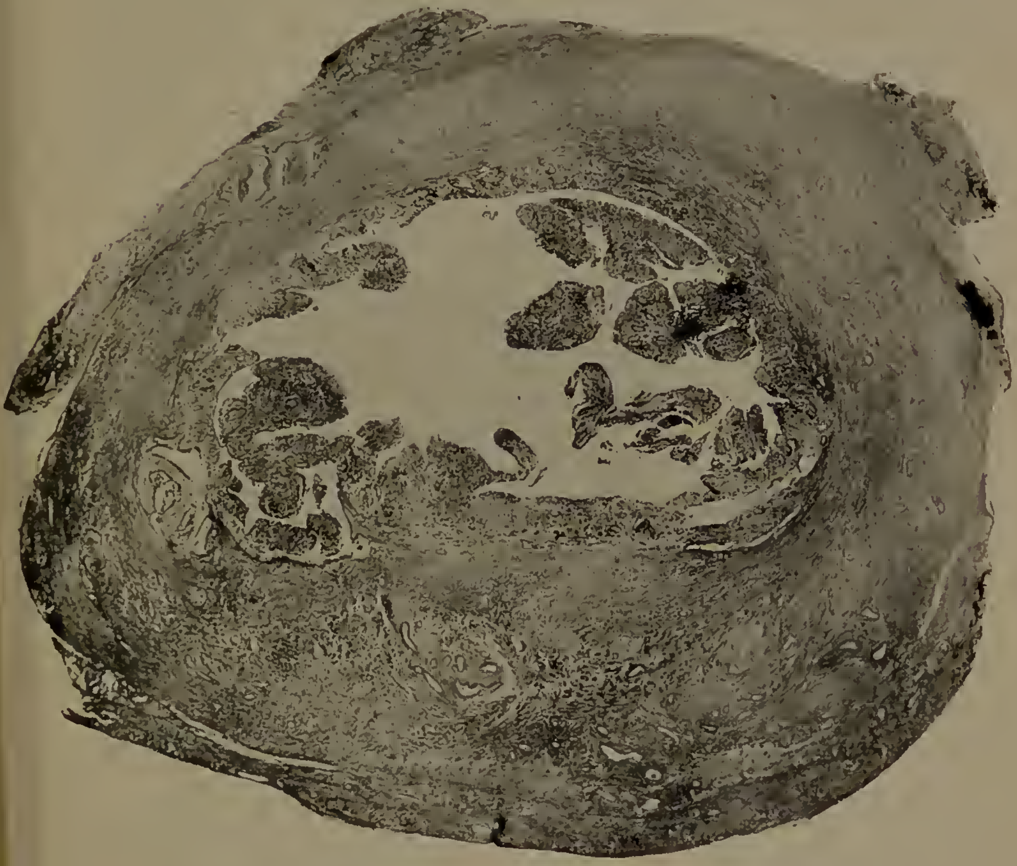
Primary Tuberculosis of Fallopian Tube. × 100. (Author.)
Section from tube, Plate XLIX.

PLATE LI.



Acute Tuberculosis of Fallopian Tube. × 50. (J. Stevenson.)
From a case operated upon in Landau's Klinik. [*To face p.* 643.

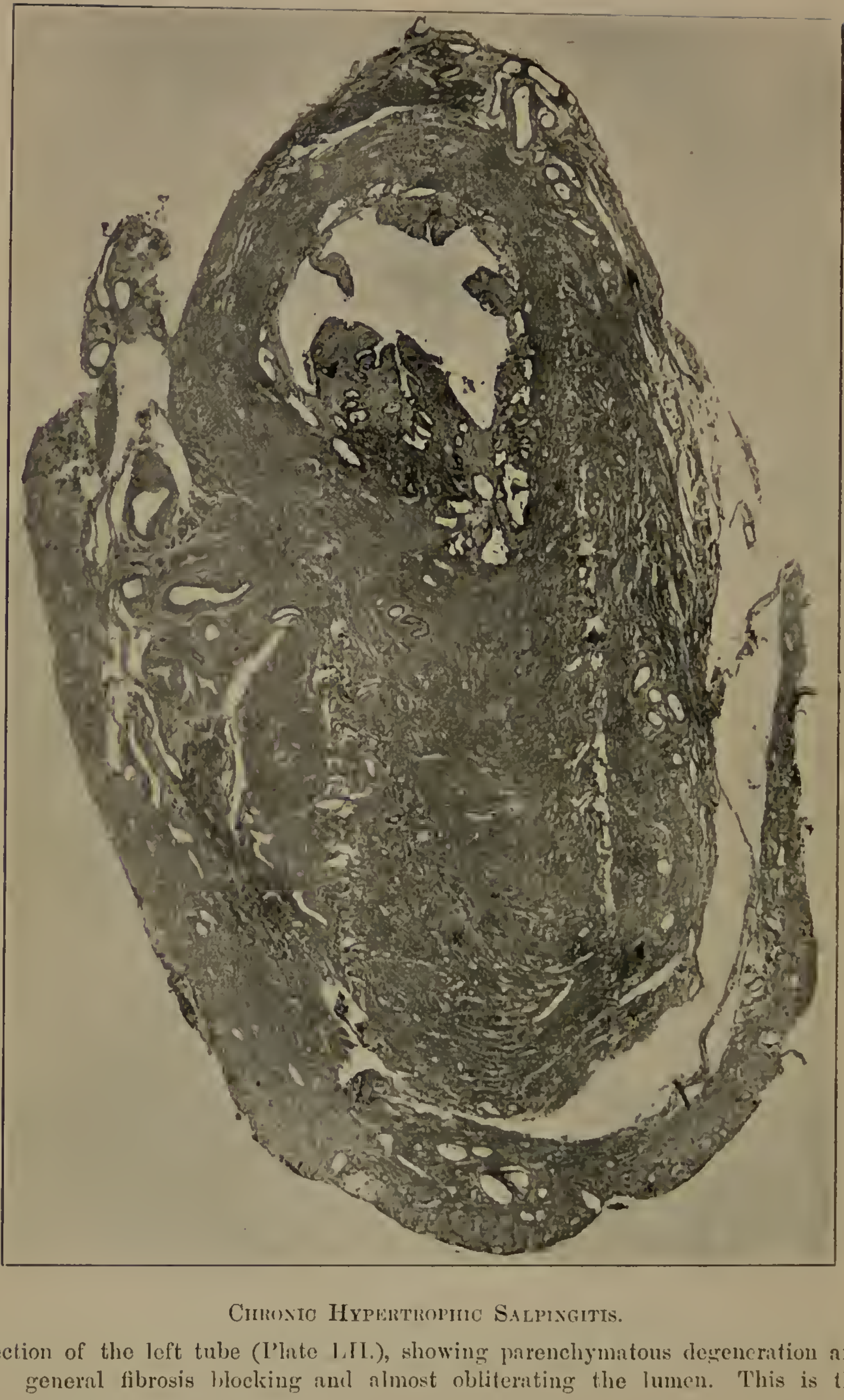
PLATE LII.



Section of the Tube. (Author.)

Magnification 8 times. Mucosa replaced by granulations—only a few columnar tubes left to represent plicæ. There is a round-celled infiltration under the peritoneum, surrounded by a fibrous capsule; infiltration of the musculo-fibrous wall, its vessels having hypertrophied walls. [*To face p.* 648.

PLATE LIII.

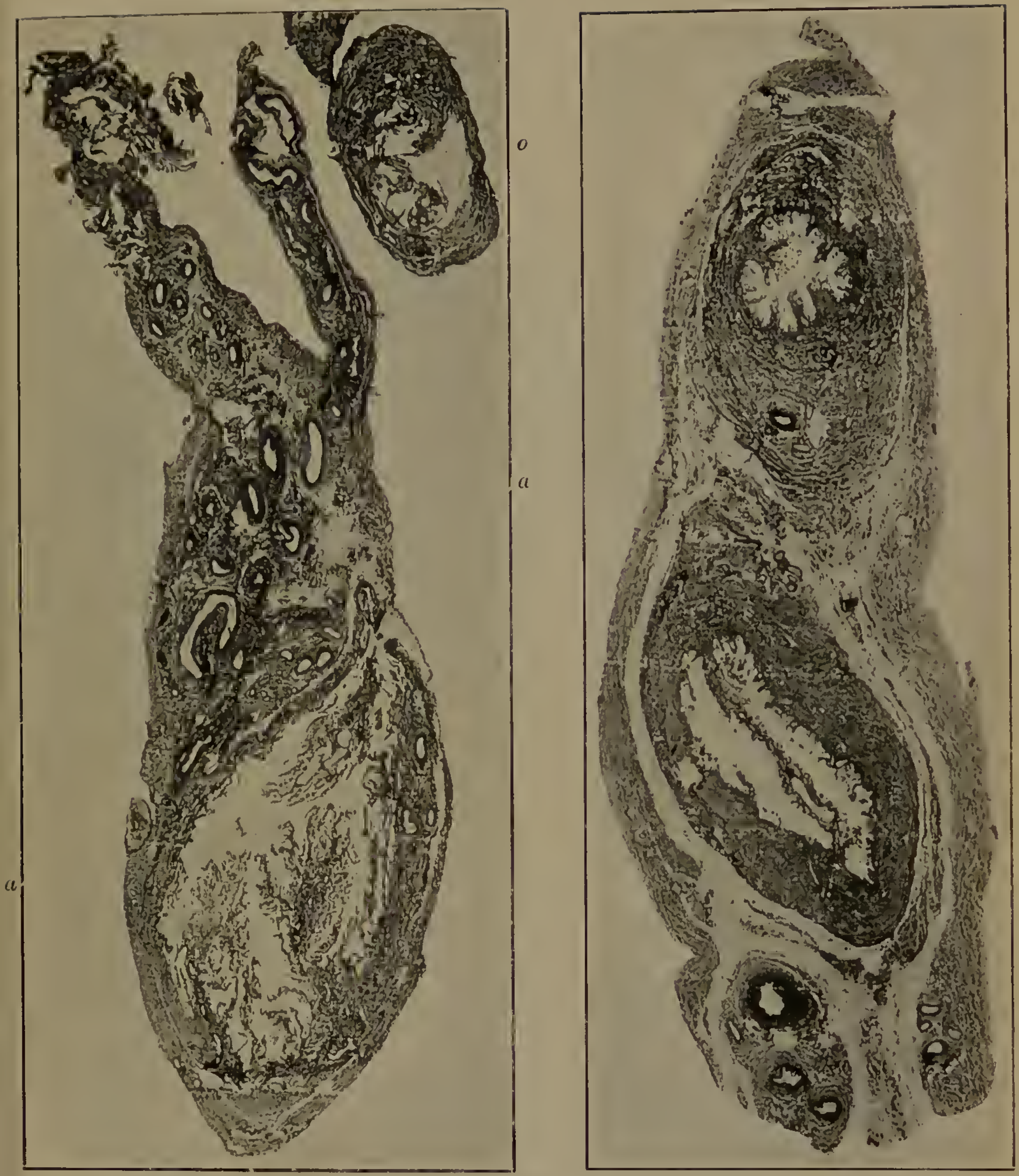


Chronic Hypertrophic Salpingitis.

Section of the left tube (Plate LII.), showing parenchymatous degeneration and general fibrosis blocking and almost obliterating the lumen. This is the secondary or atresic stage.

[*To face p.* 649.

PLATE LIV. PLATE LV.



Transverse Section of Fallopian Tubes exemplifying Hypertrophic and Desquamative Salpingitis. (See Plates LVI. and LVII.)

Plate LIV.—Left tube. A portion of the ovary (*o*) is included in the section; the plicæ are swollen, and there is general desquamation of the cubical epithelium, with partial obliteration of the lumen of the tube. *a*—*a* limit of ovary.

Plate LV.—Right tube is also the seat of desquamative salpingitis. It is folded on itself, and dissection is made through the loop. The plicæ here are œdematous, and the lumen of the tube is encroached upon.

[*To face p.* 652.

PLATE LVI.

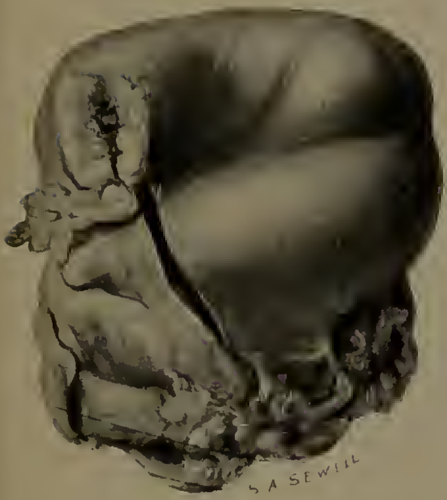
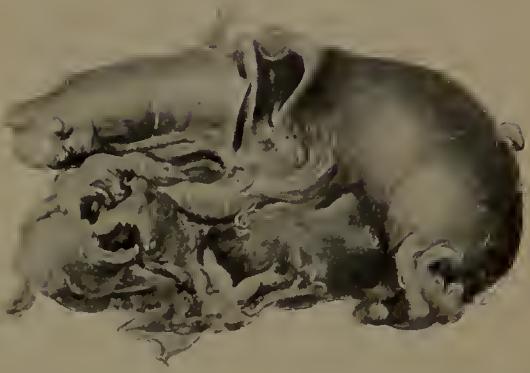


PLATE LVII.



Adnexal Tumours.

The right tube (Plate LVI.) is much dilated and presents an omega loop, the two limbs of the loop being closely united together and blended with the ovary, so that no mesosalpinx is apparent. The loop of tube measures 8 cm. The fimbriated external and the uterine cut ends lie side by side, both being attached to the ovary, which lies immediately beneath. The ovary contains a blood cyst. Its vertical diameter measures 2 cm. Its surface is roughened by adhesions, and presents a rupture produced possibly in separating the adhesions at the time of operation.

The left tube and ovary (Plate LVII.) present a fused mass, of smaller size than that on the right side. The tube is gradually distended, from the uterine to the distal extremity. The abdominal ostium is closed, being sealed to the ovary.

A careful microscopical examination of these tubes and ovaries presented all the appearances present in chronic salpingo-oöphoritis, the tube at the left side being incorporated with the tissue remains of a contracted and thickened mesosalpinx, while the corresponding ovary was a typically sclerosed ovary with all the characteristic appearances seen in old standing chronic ovaritis. In the right ovary there was cystic degeneration, and the appearances presented were those of commencing ovarian adenoma. (C. L.)

[*To face p.* 654.

(*See over page.*)

OPERATION (PLATES LVI., LVII.).

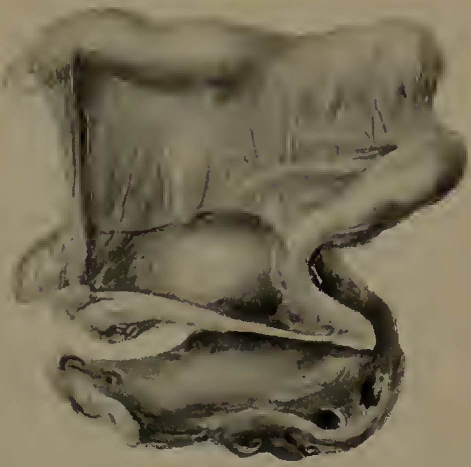
Appearances presented when the Abdomen was opened, and the Steps necessary for the Removal of the Embedded Adnexa—Notes taken at the Operation.

Left tube could be traced to the outer extremity. Uterine cornua greatly hypertrophied, and the uterine fibres continuous with the uterine end of the tube for some distance. Omentum and bowel adherent to the plastic layers covering the broad ligament. The ovary is covered by this layer, and is not visible, but could be felt. At the right side neither tube nor ovary were to be seen. A smooth membranous covering concealed both; tracing the broad ligament out to the pelvic wall at its outer side a large mass could be felt, apparently between the layers of the broad ligament. At the left side the adhesions of bowel and omentum having been separated, the tubo-ovarian vessels were tied off and the broad ligament clamped with Bilroth's and Kocher's clamp, one close to the uterus. The thickened cornu and the ligament were secured, and the adnexal mass removed. At this side, a large branch of the uterine artery was divided in order to get well below the mass. At the right side the separation of the mass was more difficult, as it was more embedded and incorporated with the broad ligament, the upper two-thirds, which had to be removed with it. This ovary was also cystic, and its contents were sanguineous. The tube was like the left one, and its uterine end enormously thickened, and the uterine cornu, as in the other case, also hypertrophied. Patient made an excellent recovery.

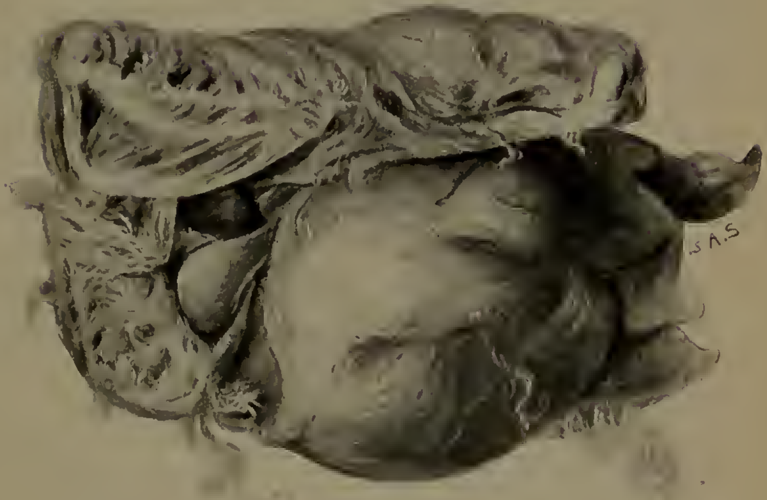
PLATES LVIII., LIX., AND LX.

Adherent adnexa removed by salpingo-oöphorectomy. At the left side desquamative salpingitis with cirrhotic ovary. At the right side an ovarian blood-cyst and desquamative salpingitis. The entire adnexa of this side were embedded in adhesions, and were incorporated with the broad ligament, which had to be divided as far as the uterine artery in order to remove the mass.

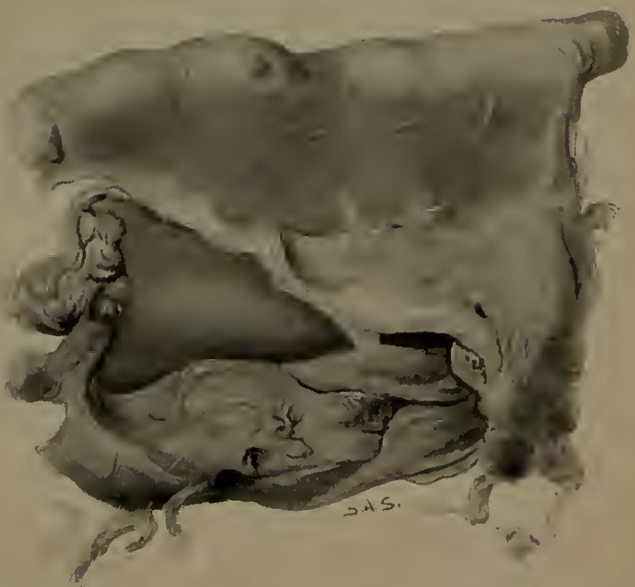
Uninterrupted recovery.



LEFT ADNEXA.



RIGHT ADNEXA.



POSTERIOR ASPECT OF MASS, WITH APRON OF EXUDATION.

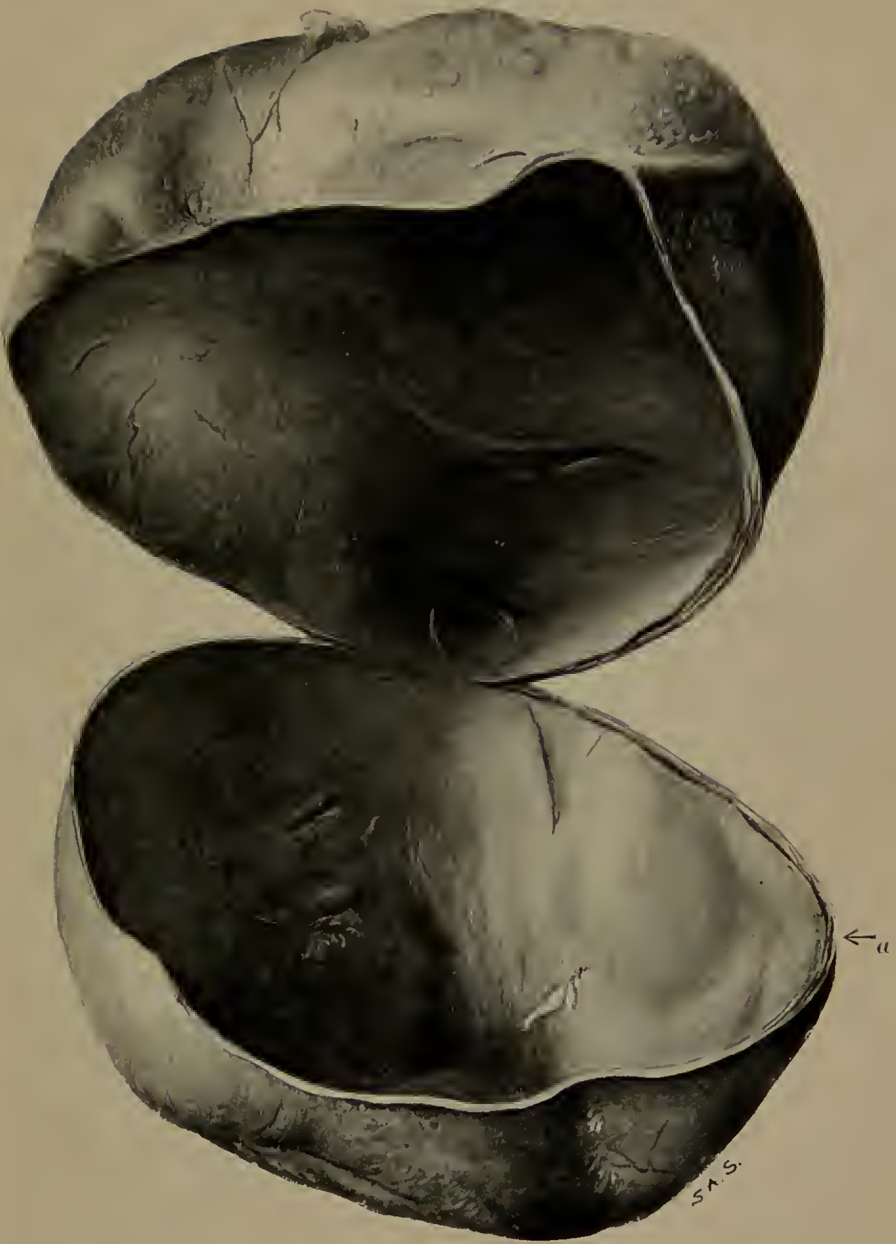
(See over page for description.)

Histological Report (Plates LIX., LX.).

The right tumour consists of a portion of the right tube, attached to which is the corresponding meso-salpinx and a portion of the ovary of this side, together with many adhesions. Apart from the above there is a "blood-cyst." The latter fits into the severed ovary without any apparent loss of tissue. The adhesions mentioned are extensive enough to cover the two structures like an apron when they are placed in apposition. The tube is enlarged slightly; it measures 10 cm. in length and 1 cm. in diameter. It is invested by adhesions, which pass off from its attached border, and, concealing the meso-salpinx, run downwards to cover the ovary and cyst. These adhesions have dragged up the ovary towards the tube, thus causing a shortening and thickening of the meso-salpinx. A section of the tube shows a thickened serosa, and a similar condition of desquamation of the cubical epithelium of the swollen plicæ as was observed in the tube of the opposite side. The ovary shows a thick investment of fibrous lymph, and a densely infiltrated stroma. The wall of the blood-cyst is lined by festoons of lutein cells, showing that it arose from a ripe corpus luteum. It is, in fact, a lutein cyst. (Cuthbert Lockyer.)

[*To face p.* 655

PLATE LXI.

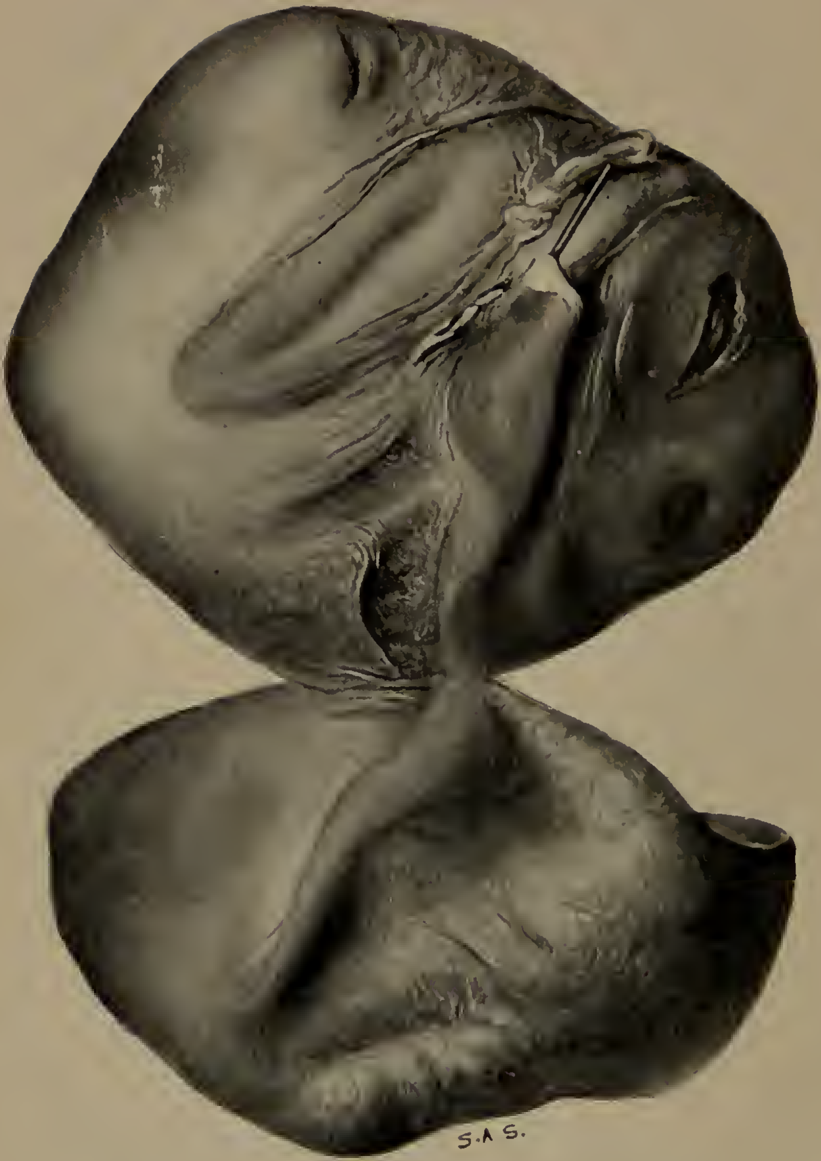


True Tubo-ovarian Cyst. (J. Taylor.)

a, opening of the Fallopian tube. True tubo-ovarian cyst of the left side removed by posterior vaginal cœliotomy on January 21, 1904. The patient was 31 years of age, married, and had had a smaller tubo-ovarian cyst (of the right side) removed five years previously by the same method. The fluid of the cyst was slightly brownish, and tinted as if mixed with a little blood, a secretion from the tube. No adhesions. Iodoform-gauze-drainage of Douglas. Recovery.

[*To face p.* 658

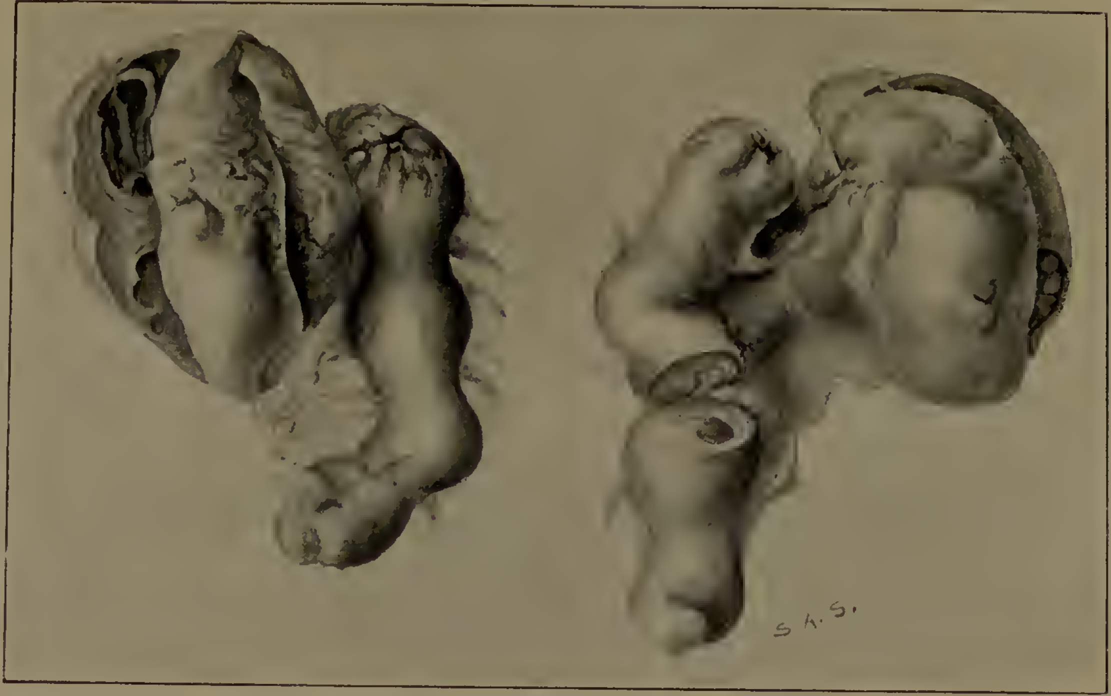
PLATE LXII.



Outer Surface of the Cyst, with the Incorporated Fallopian Tube.
Tubo-ovarian Cyst.

[*To face p.* 659.

PLATE LXIII.

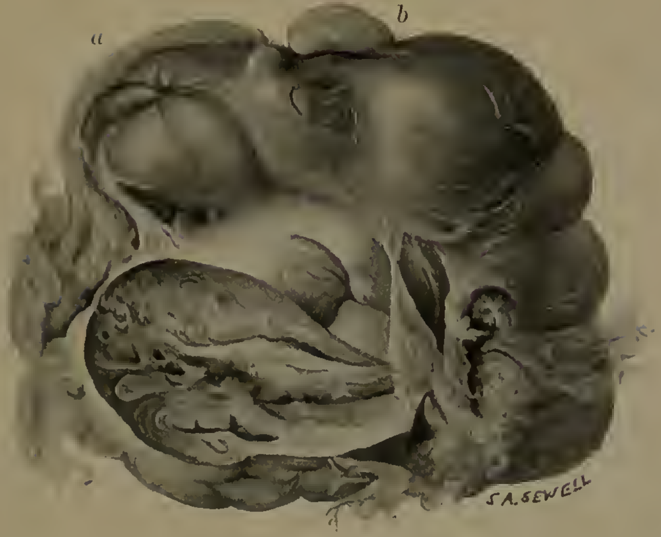


NODULAR SALPINGITIS. (AUTHOR.)

Cystic ovaries, with tubes. The tubes present the naked-eye appearance seen in nodular salpingitis. This case was not tubercular.

[*To face p.* 662.

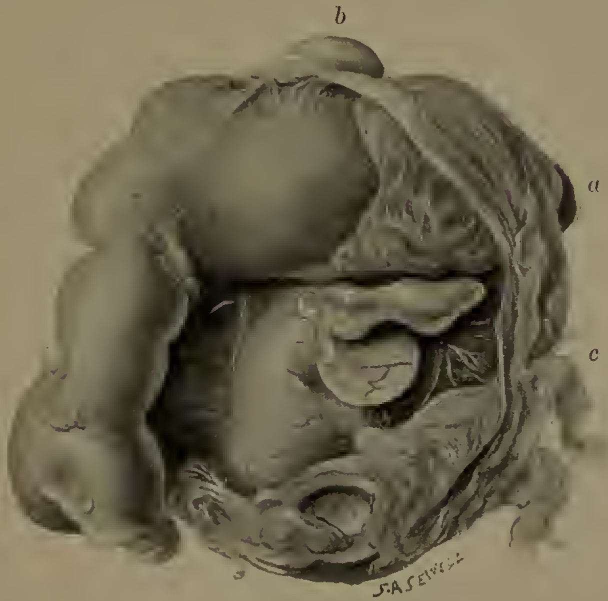
PLATE LXIV.



POSTERIOR SURFACE.

See Plate XCIV. for large left ovarian hæmato cyst removed at the same time.

PLATE LXV.

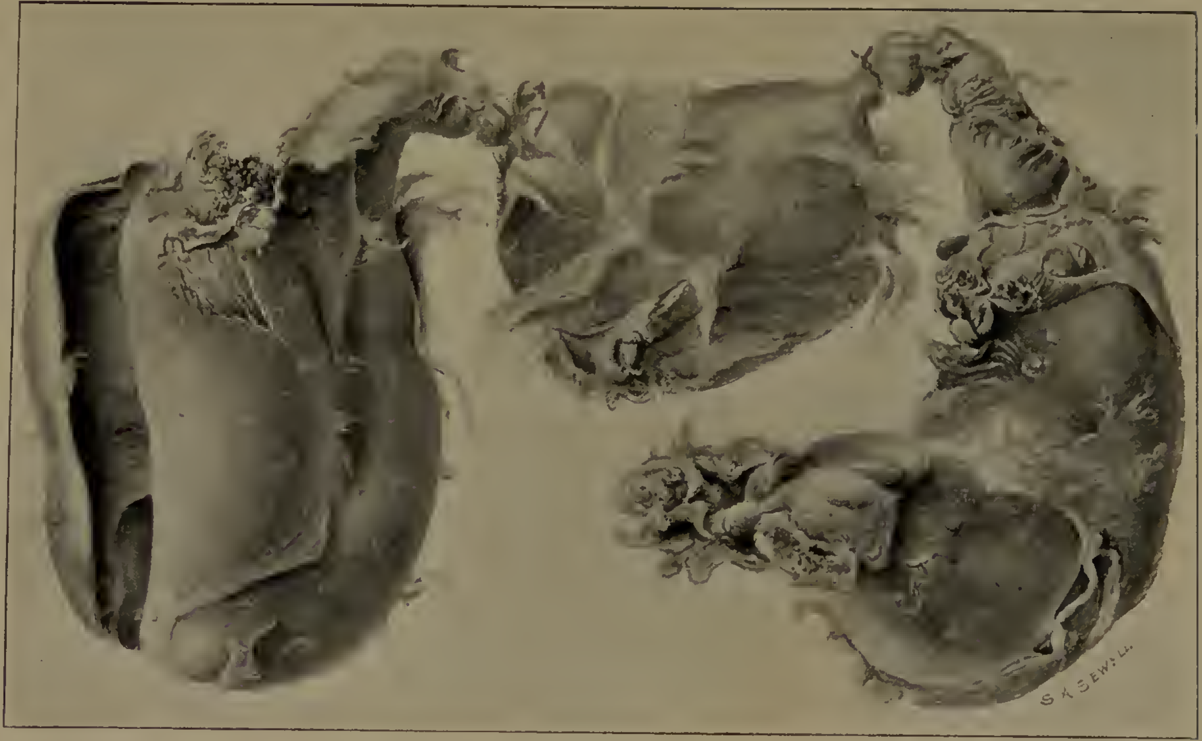


ANTERIOR SURFACE.

Left hydrosalpinx, with large cystic ovary and cysts of the meso-salpinx. The tube and ovary forming a mass with the meso-salpinx.

The uterine appendages of the right side. The ostium (*a*) is closed, and the tube is in an early stage of hydro-salpinx, its ostial end *only* being distended by fluid to the size of a pigeon's egg, while its uterine portion is simply thickened. The fluid contains a considerable amount of granular débris, which appears to consist chiefly of degenerate epithelium. Within the distended portion of the tube numerous plicæ can be seen. Above it is attached a tiny cyst—probably a hydro-salpinx of an accessory tube, while below it, attached to the broad ligament in the region of the parovarium, are three minute thin-walled cysts. Numerous adhesions are present, especially between the ovary and the hydro-salpinx. [*To face p.* 667.

PLATE LXVI.

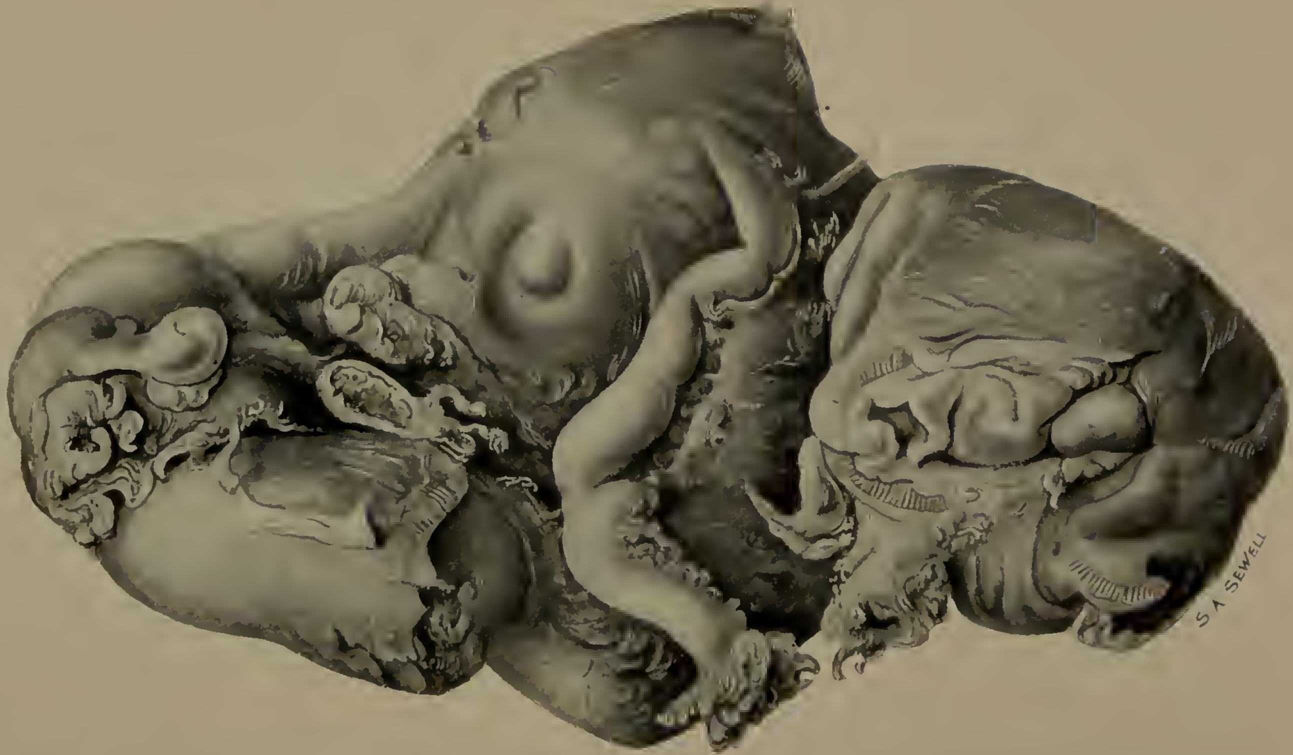


Double Pyo-salpinx.

Salpingo-oöphoro-supra-vaginal hysterectomy—showing the pus tubes and large ovarian sacs—the left was ruptured in removal. the right was removed without rupture. The uterus and ovaries were embedded in a dense and hard infiltration filling the pelvis. The patient made an excellent and permanent recovery.

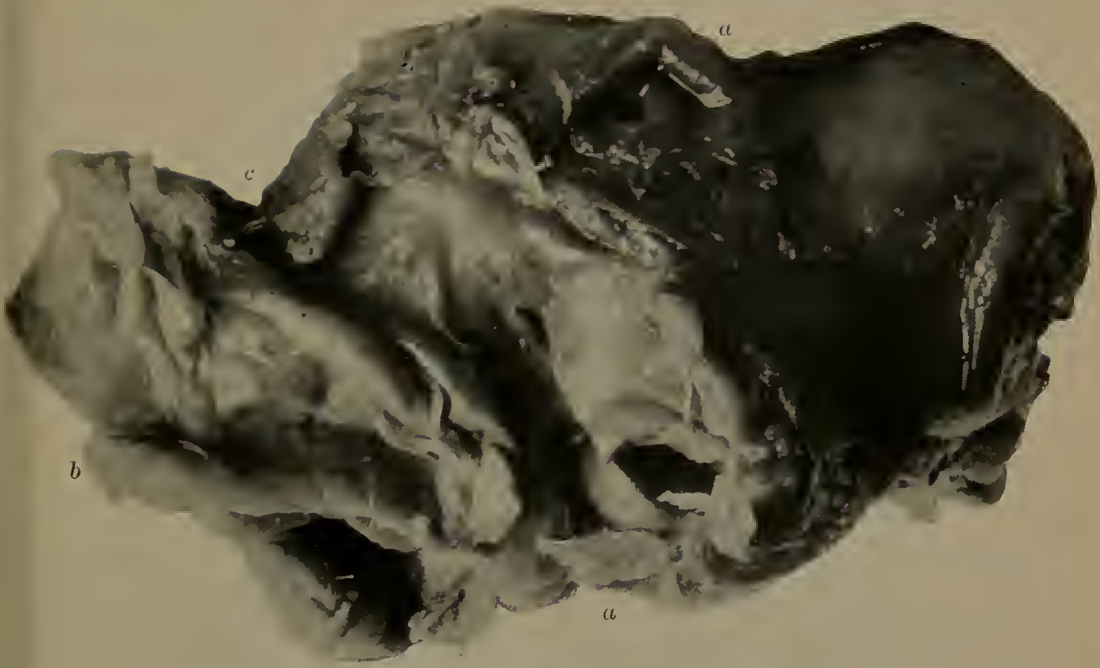
[*To face p.* 676.

PLATE LXVII.



Double Pyo-salpinx, each large Pus Sac communicating with the Uterine Cavity. (T. Gelston Atkins.)
Removed by abdominal pan-hysterectomy. [*To face p.* 677.

PLATE LXVIII.



CARCINOMA OF THE FALLOPIAN TUBE.

a, *a*, solid portion of tumour; *b*, tube; *c*, capsular portion.

This specimen I found recently in my private collection and cannot trace the clinical particulars of the case.

The tumour is oval in shape, and measures 10 inches in its greatest, and 8 inches in its shortest, circumference. It has a lobulated surface; some of the lobes are smooth, the growth being enclosed in a tightly stretched fibrous-looking shiny capsule. Other lobes are rough and papilliform, consisting of growth which has burst through the containing capsule. The smooth thin capsule has been peeled off the greater part of one portion of the growth, revealing a rough surface studded with nodules the size of a pin's head. A further portion of the tumour has been cut through its greatest diameter; the cut surface has a pale yellow colour, and consists of soft friable granular-looking material. At one point there was a small projection which admitted a fine bristle. This on transverse section proved to be the cut end of the Fallopian tube. On following this up, it was found to lead through the capsule into the cavity containing the new growth (*b*).

Microscopical Report (Cuthbert Lockyer).—Sections have been prepared at various levels to show that the capsule of the growth is continuous with the wall of the undilated tube. These sections prove that the smooth capsule enclosing the tumour consists of fibro-muscular tissue continuous with that forming the wall of the unexpanded tube. The tumour is, in fact, of tubal origin.

Section I. showed a thickened tube-wall with intact lumen, and with swollen, but perfect, plicæ. The vessels are thickened, and contain thrombi. The main lymphatics are injected by leucocytes, but contain no deposit of new growth.

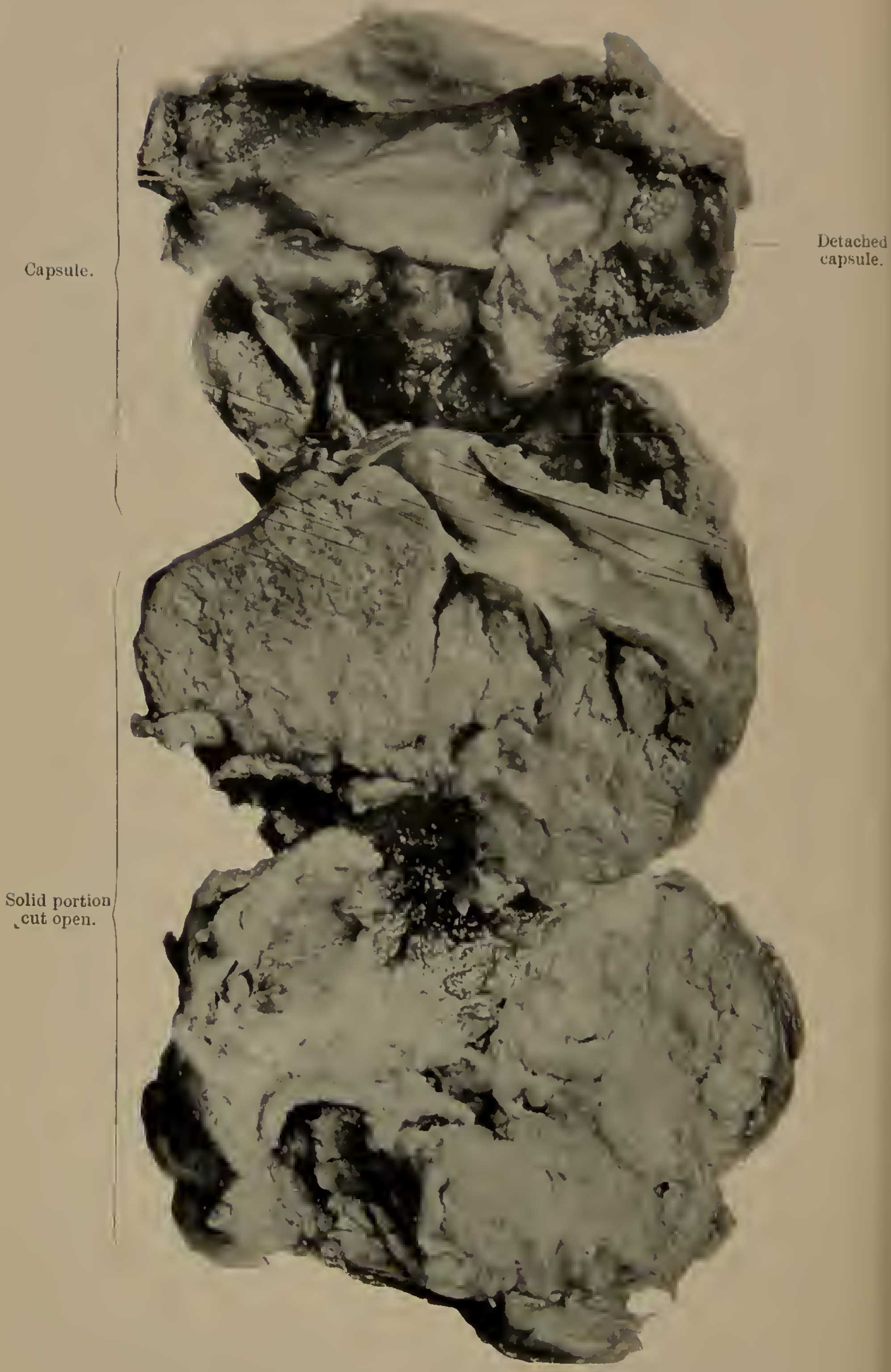
Section II., taken a little further on, showed a portion of tube-wall with carcinomatous growth arising from and distorting the still existent plicæ.

Section III. showed a few plicæ, but the majority have disappeared, giving place to columns of cancer cells densely packed together, and which have lost their columnar shape and have become more or less spheroidal. These lie in close apposition to the stretched wall of the tube: the latter is here invaded by cancer cells, which occupy alveolar spaces (lymphatics) between the fibro-muscular layers.

Section IV., taken furthest from the non-dilated end of the tube, shows a much thinned-out tubal wall, forming the capsule to a dense solid carcinomatous growth, composed of densely packed spheroidal cells, arranged in long columns and concrete masses. (C. Lockyer.) [*To face p.* 678.

(*See over page.*)

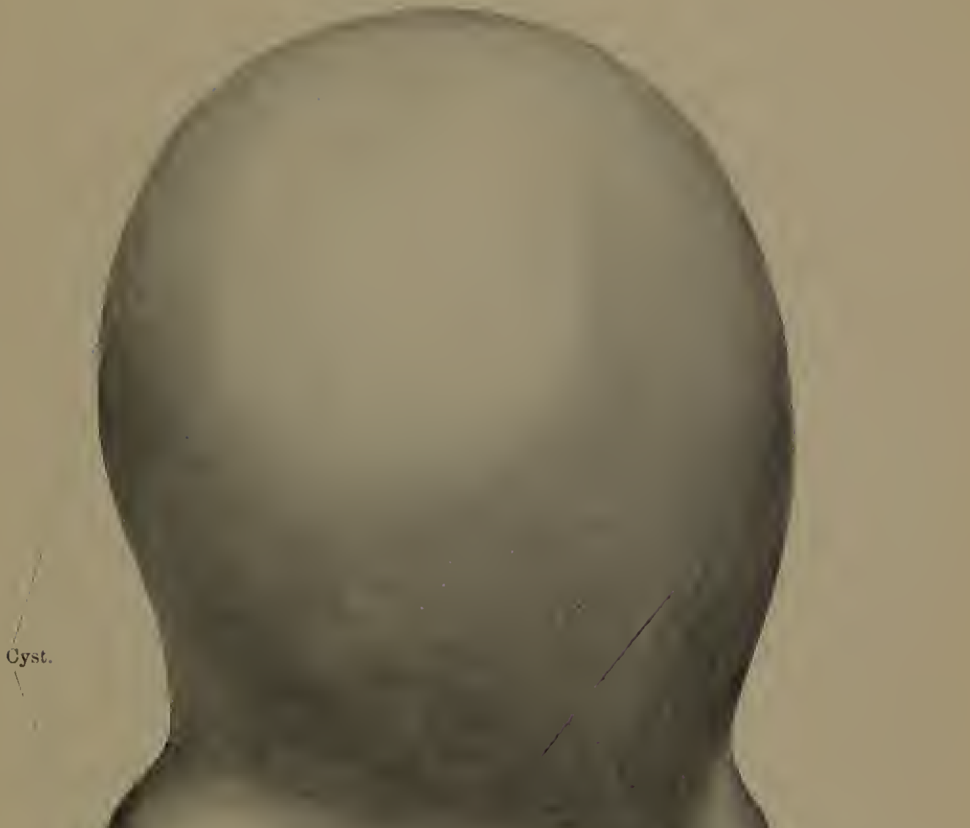
PLATE LXIX.



Carcinoma of the Fallopian Tube—Tumour laid open.

[*To face p.* 679.

PLATE LXIXa.



Hydatid Cyst (Echinococcus) of the Fallopian Tube.* (T. W. Eden.)

Measurement of cyst, $4\frac{1}{2}$ in. in vertical, by 3 in. in the transverse, and $2\frac{1}{2}$ in. in the antero-posterior diameter. The average thickness of the wall was $\frac{1}{8}$ of an inch.† See other side for description of cyst.

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* See also pp. 860, 951.

† *Jour. Obs. and Gyn. Brit. Emp.*, July, 1904.

(*See over page.*)

[*To face p.* 682.

This tumour * (Plate LXIXa.) was removed, by abdominal cœliotomy, by T. W. Eden, from a patient aged 40. The cyst was in the pouch of Douglas, and firmly adherent to the surrounding structures. In appearance it was not unlike an ovarian dermoid with cartilaginous walls. The tumour consisted of the right uterine appendages, including a functionally active ovary, Fallopian tube, and meso-salpinx. The inner third of the tube was not much altered macroscopically, while the upper border of the outer two-thirds was closely incorporated with the hydatid cyst. The tubal canal was intact, and had no communication with the cavity of the cyst, the wall of the latter being incorporated with that of the tube by a firm organic union. The abdominal ostium was sealed. There was no evidence of any hydatiform affection in any other organ. The surface of the cyst was roughened by remains of adhesions. Examination of the cyst proved it to be a hydatid with hydatid vesicles, containing large numbers of broad capsules and free hooklets. Eden considers that the origin of the hydatid cyst was due to the deposition of ova 'in the tissues of the upper wall of the tube, and their development in that position was sufficiently slow and gradual to avoid rupture either into the peritoneal cavity or the tubal canal.' Eden quotes Péan's case of hydatid of the ovary,† and a case of Doléris (1896) of hydatid of the Fallopian tube, as the only two previously recorded cases of undoubted primary hydatid disease of the ovary or Fallopian tube.‡

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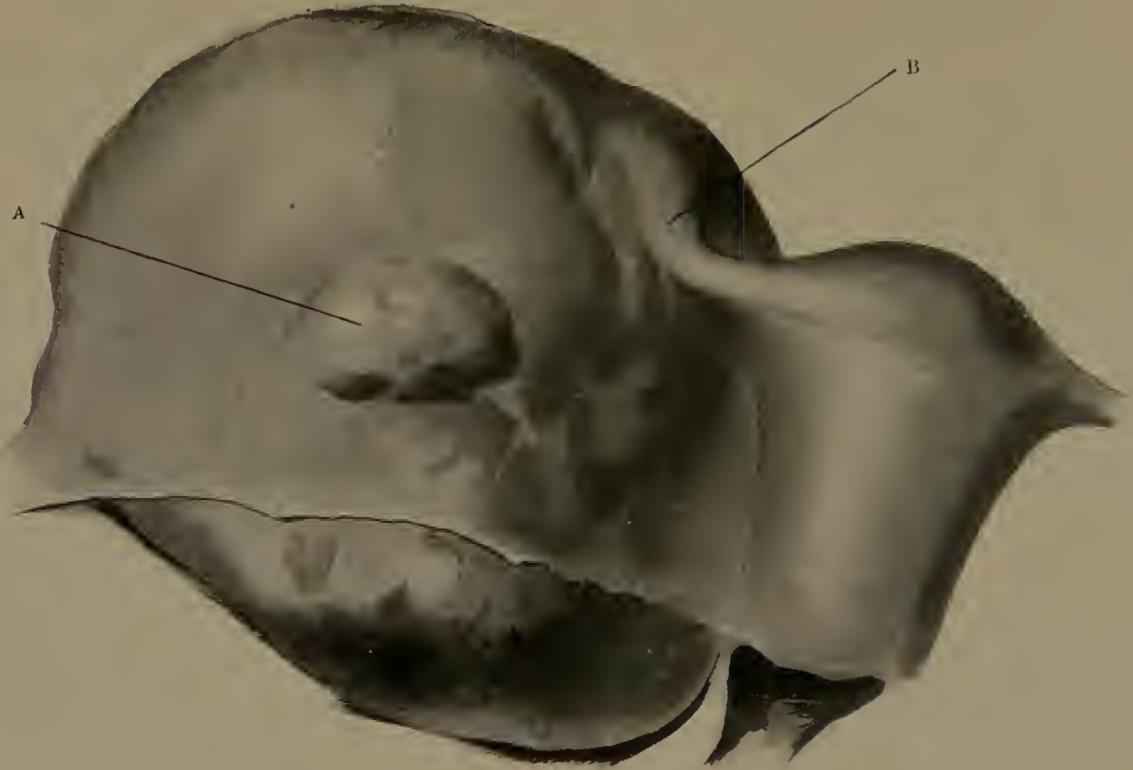
* See pp. 861 and 951 for instances of hydatid cysts of the uterus.

† 'Diagnostique et Traitment des Tumeurs de l'Abdomen,' vol. iii. p. 671.

‡ *Jour. Obstet. and Gyn. Brit. Emp.*, July, 1904.

PLATE LXX.

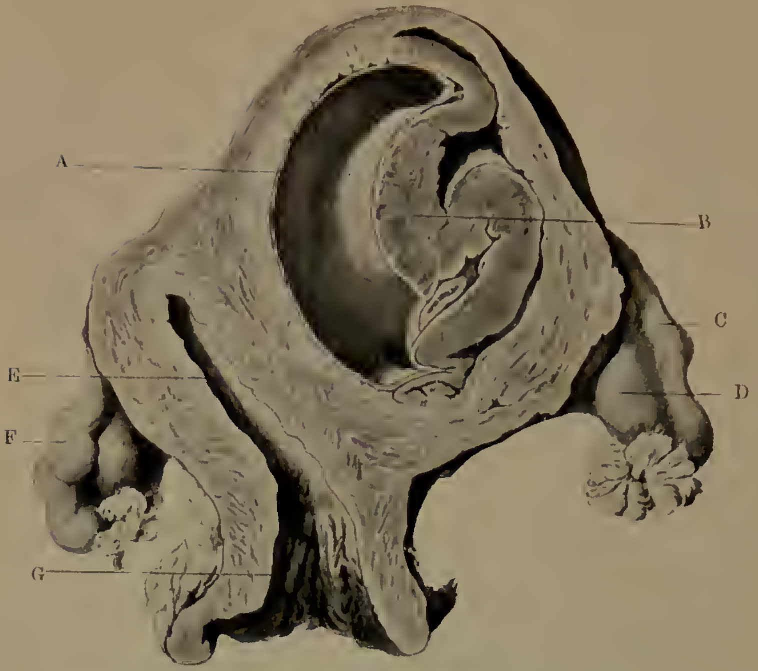


Left Intraligamentary Gestation. (Bumm.)

A, ovary; B, left tube.

The sac had developed between the layers of the broad ligament as far as the vault of the vagina, and was completely enucleated without any injury to the sac. [*To face p.* 690.

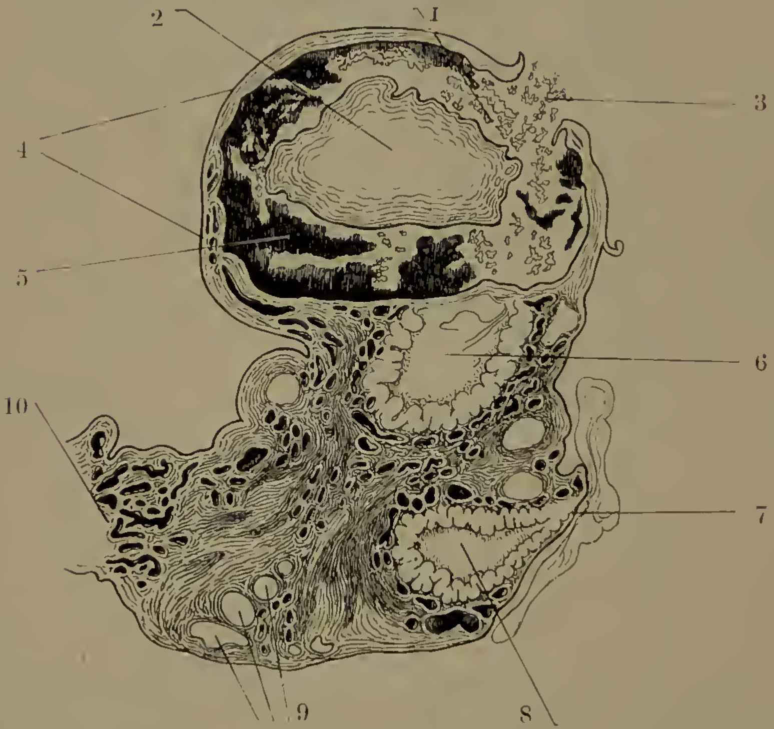
PLATE LXXI.



Interstitial Gestation at the Fourth Month. (Bumm.)

Reduced ⅓. A, cavity of the ovum; B, placenta; C, right tube; D, ovary; E, uterine canal; F, right adnexa; G, dilated cervix.

PLATE LXXII.



Ovarian Gestation.* Rupture in the Sixth Week. (C. Van Tussenbroek. from Bumm.)

1, chorion; 2, cavity; 3, rupture of sac wall; 4, wall of the sac formed from an expansion of the wall of corpus luteum; 5, blood coagula; 6, diverticulum of a corpus luteum; 7, opening of a corpus luteum blocked with fibrine; 8, diverticulum of the luteum; 9, follicles; 10, hilum of ovary.

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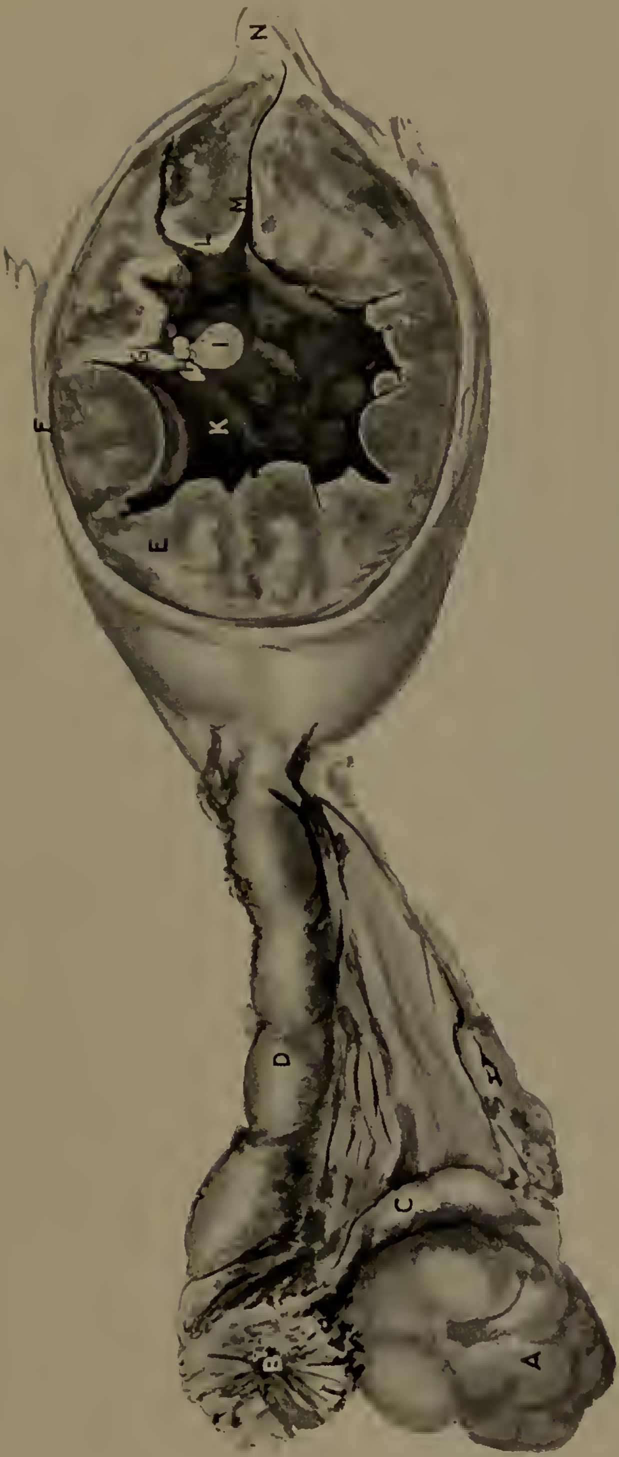
* *Annals of Gynæcology*, 1899.

[*To face p.* 691.

PLATE LXXIII.



A, adherent right ovary; B, ostium-patent; C, infundibulo-pelvic ligament; D, right tube; E, blood clot containing chorionic villi; F, inner third of tube; G, abdominal pedicle; H, embryo; I, umbilical vesicle; K, amniotic cavity; L, amnion; M, lumen of tube not communicating with amniotic cavity; N, uterine end of tube.

UNRUPTURED TUBAL GESTATION IN WHICH THE EMBRYO HAS PERISHED DURING THE FOURTH WEEK FROM HÆMORRHAGE INTO THE MEMBRANES. (MARY SCHARLIEB.)

Removed successfully by operation three months later.

[*To face p.* 699.

Clarence Webster has recently recorded a case of undoubted ovarian pregnancy. The detailed description of the histological features of the tumour will be found in the *American Journal of Obstetrics*, July, 1904. The ovum was situated entirely within the substance of the ovary. There was no corpus luteum present in the gestation sac, showing that the ovum was not fertilized in a ripe follicle. Webster, advocating the development of the human fertilized ovum in tissue derived from the Müllerian duct, and the extension of Müllerian tissue into the ovary, taken in conjunction with the observations of Schmorl, and others, which showed the occasional occurrence of decidual-like cells in the ovary in cases of uterine pregnancy, suggests that these areas—detached portions of Müllerian tissue—through a special genetic reaction determine the embedding and growth of a fertilized ovum in the ovary.*

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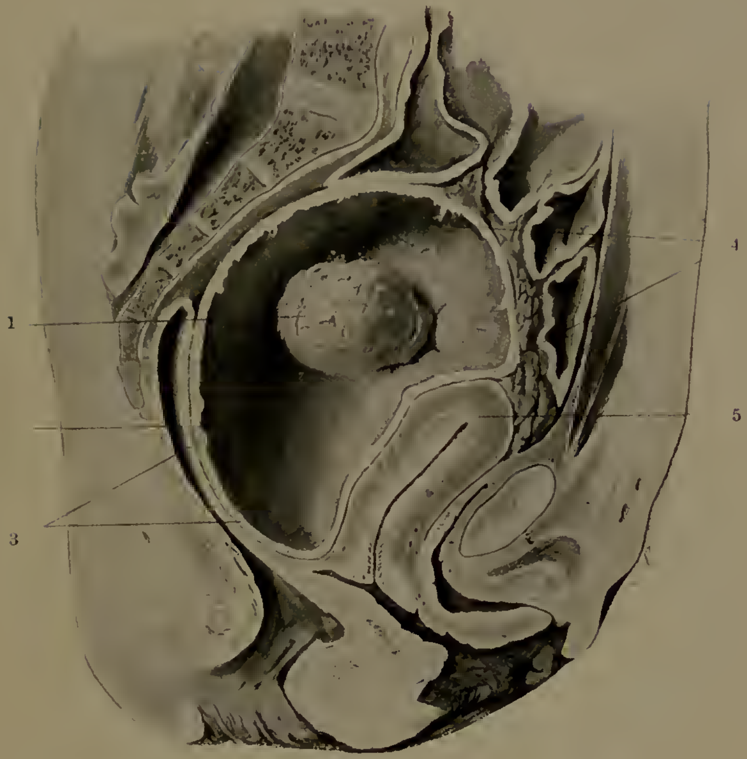
* Williamson, *Jour. Obst. and Gyn. Brit. Emp.*, Sept., 1904.

PLATE LXXIV.

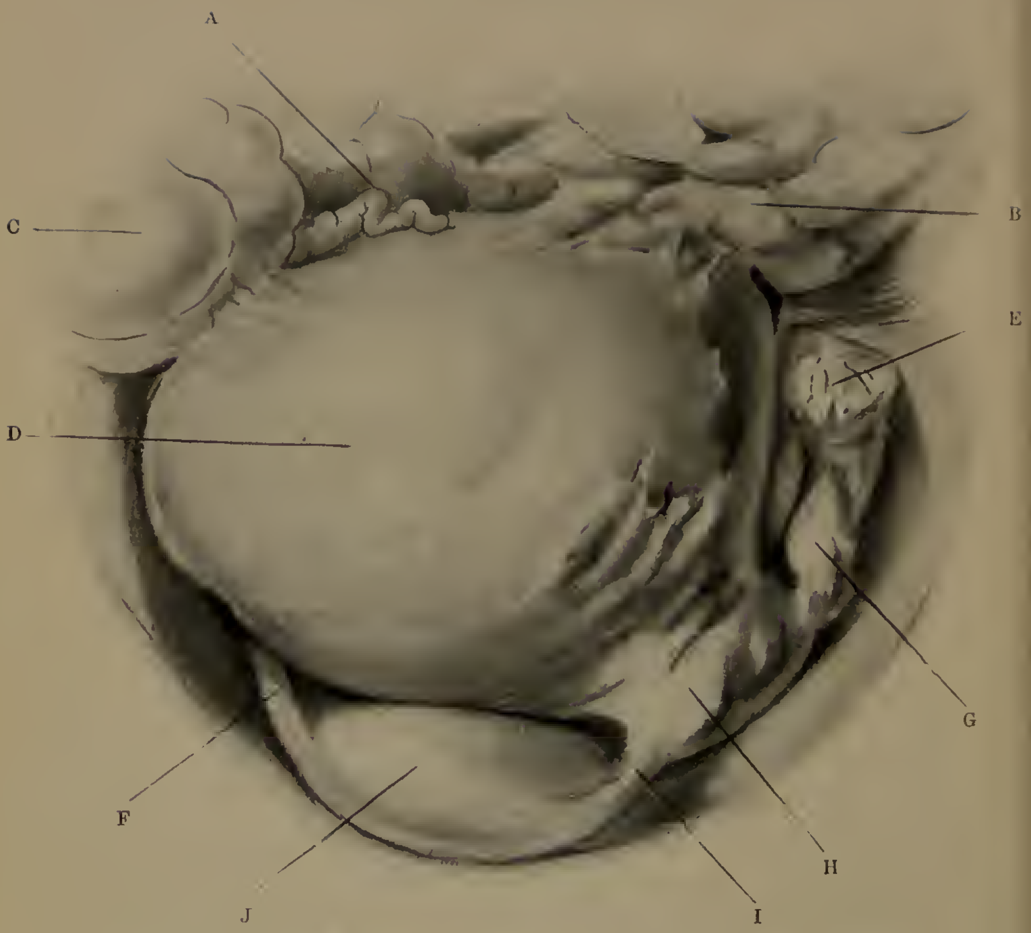


Hæmatocele Retro-uterine—Tubal Abortion. (Bumm.)

1, ovum extruded from the tube into the cavity of the hæmatocele; 2, cavity of the hæmatocele sac filled with extravasated blood; 3 and 4, wall of the hæmatocele sac; 5, fundus uteri.

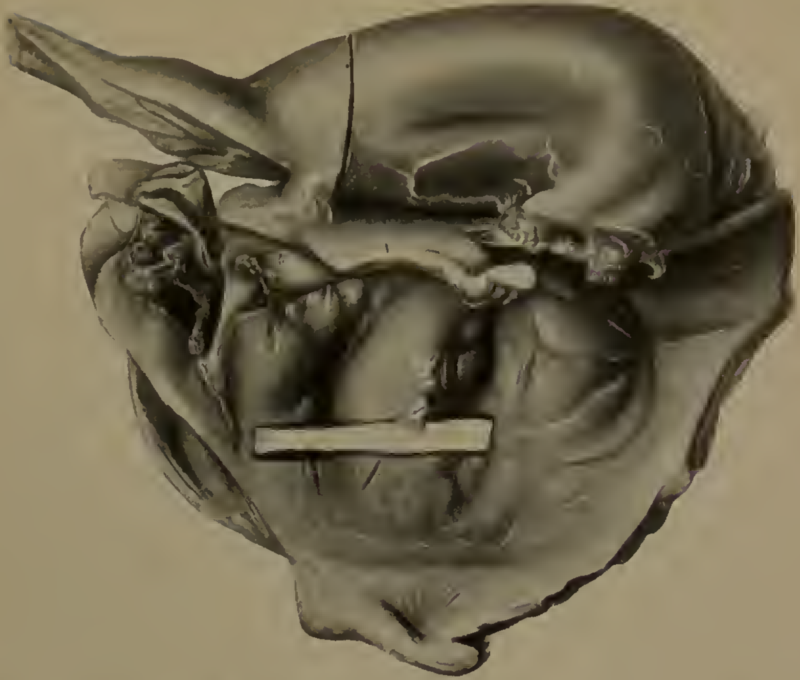
[*To face p.* 700.

PLATE LXXV.



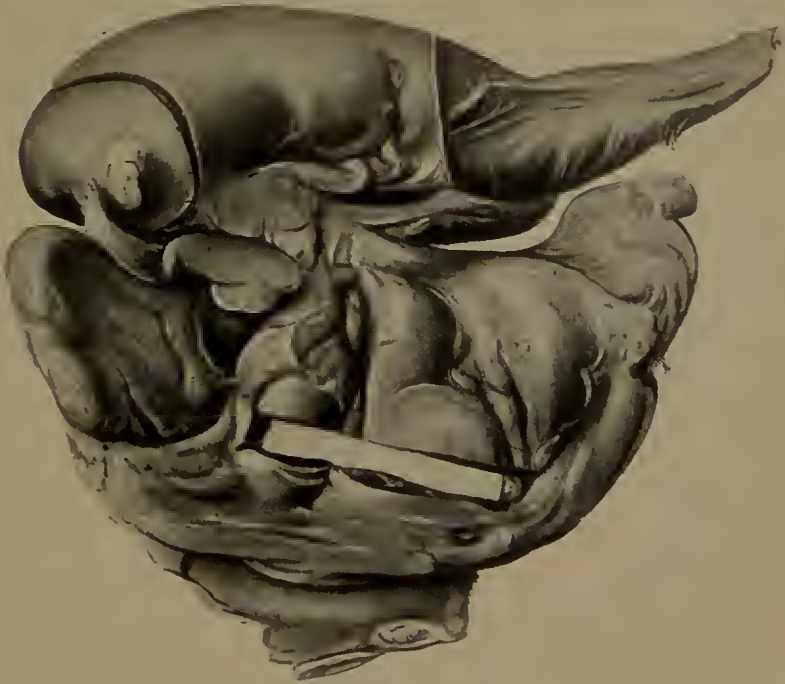
Instantaneous Photograph of Retro-uterine Hæmatocele from Rupture of the Fœtal Sac in the Isthmus of the Left Fallopian Tube. (Bumm.)

A, vermiform appendix; C, cæcum; B, sigmoid; D hæmatocele sac; E, fimbriated end of tube; G, isthmus of left tube; H. tubal gestation: I. uterine end of tube; F, right tube; J, fundus uteri. [*To face p.* 701.



RIGHT PERITUBAL HÆMATOCELE WITH THE OUTER SURFACE OF THE WALL OF THE SAC. (AUTHOR.)

The anterior wall was incorporated with the broad ligament. The window was cut into the ovarian stroma. The distended tube is seen above, the section of which, for the purpose of examination, appears at the inner pole. The ovary was flattened out on the back of the sac, and was diagnosable only on section.

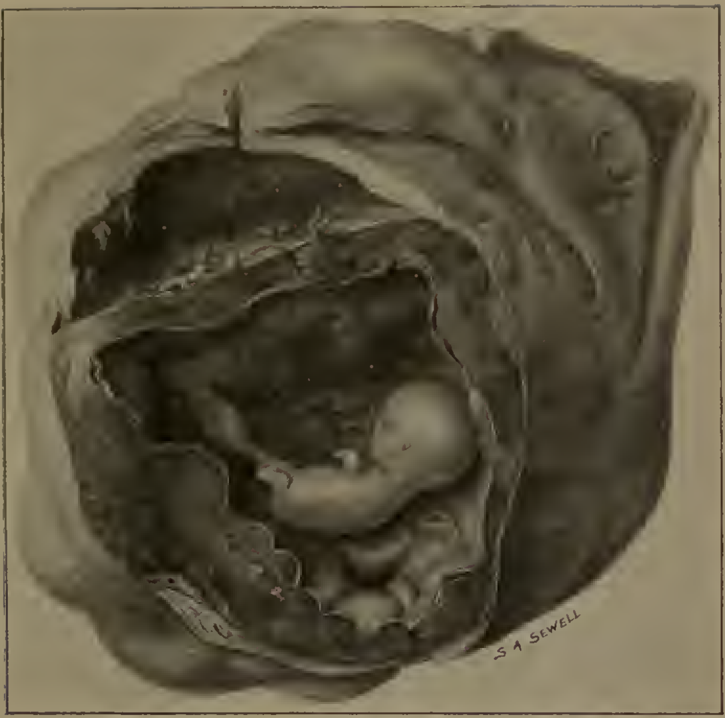


SHOWS THE ANTERIOR WALL OF THE SAC AND OVARIAN STROMA. (AUTHOR.)

The entire hæmatocele sac was removed in the manner described in the text. The section seen at the outer extremity of the tube was made for the purpose of examination. (See pp. 710, 711, for description of the gestation.)

[*To face p.* 710.

PLATE LXXVIII.



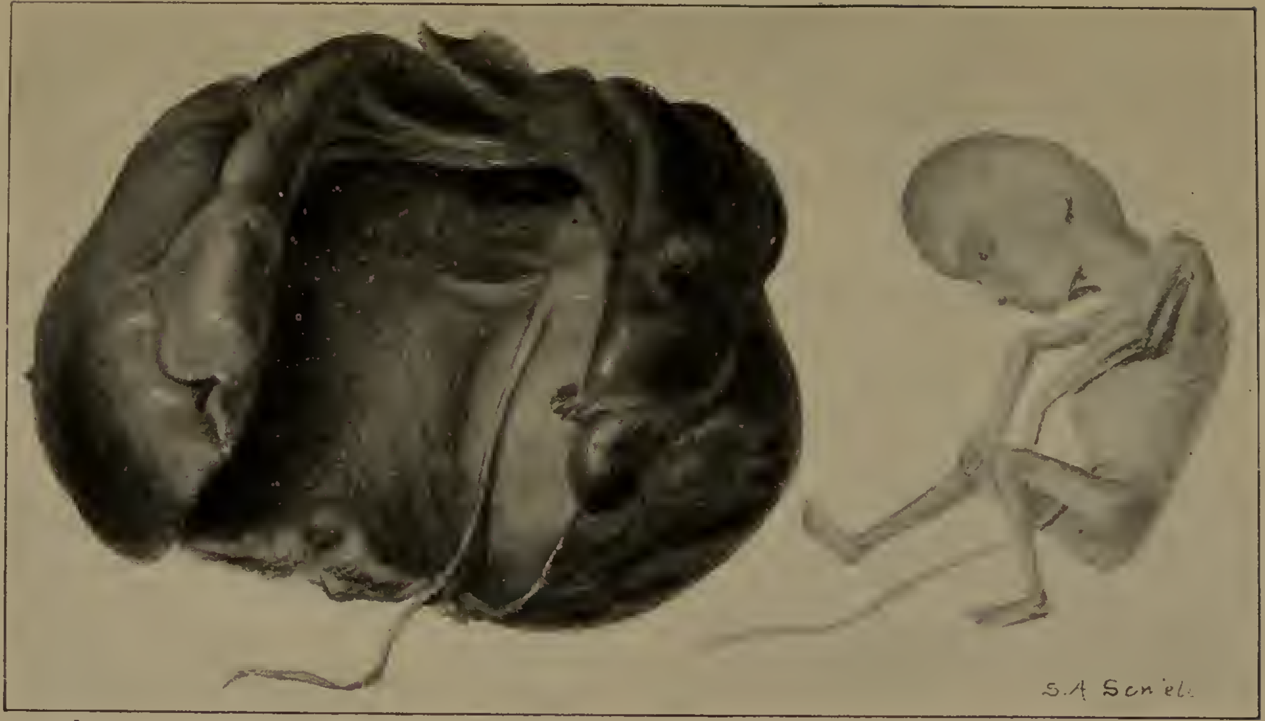
Gestation Sac with Fœtus; the Upper Cavity shown in the Drawing is that in which the Septic Fluid was contained. (Author.)

Tubal gestation, ending in molar pregnancy, with secondary suppuration, the formation of a septic sac. (H. M.-J.)

Report by Mr. Targett: ‘On section the wall of the gestation sac was found to be infiltrated with blood-clot and fibrin, as in a tubal mole. Where suppuration has occurred the placental tissue is separated from the inflamed tube by pus, and chorionic villi are in actual contact with inflammatory products. The mucous membrane of the tube is destroyed and replaced by granulation tissue. The tumour is roughly spherical in shape and measures 8 × 7 × 6 centimetres (3¼ × 2¾ × 2¼ inches) in its chief diameters after fixation in formalin. A portion of the posterior wall of the mass has been removed and reveals two cavities. The larger of these is the gestation sac containing a fœtus, while the smaller is a space formed between the gestation sac and the wall of the dilated Fallopian tube. In the recent state this latter space was filled with very offensive pus. Flattened out on the half of the tumour nearest to the uterus is the right ovary. The characters of the gestation sac are precisely those of an apoplectic or blighted ovum. It measures about five centimetres in its chief diameter, and its wall is composed largely of blood-clot in various stages of consolidation. The interior is lined with amnion, which is unevenly raised by hæmorrhages beneath it. A fœtus measuring 2·75 centimetres is attached to the wall of the sac by an œdematous umbilical cord 1·75 centimetres in length, corresponding with the stage of development at the end of the second month. The suppurating cavity, semilunar in shape, represents that part of the dilated ampulla of the tube not occupied by the gestation sac. From this relation it would appear that the tubal gestation had ended in a molar pregnancy or apoplectic ovum, and that secondary suppuration had been set up within the dilated tube and around the ovum. Consequently the pus had collected in that internal cavity which always surrounds a tubal mole owing to the ovum being adherent at only one spot upon the wall of the dilated tube.’

[*To face p.* 715.

PLATE LXXIX.

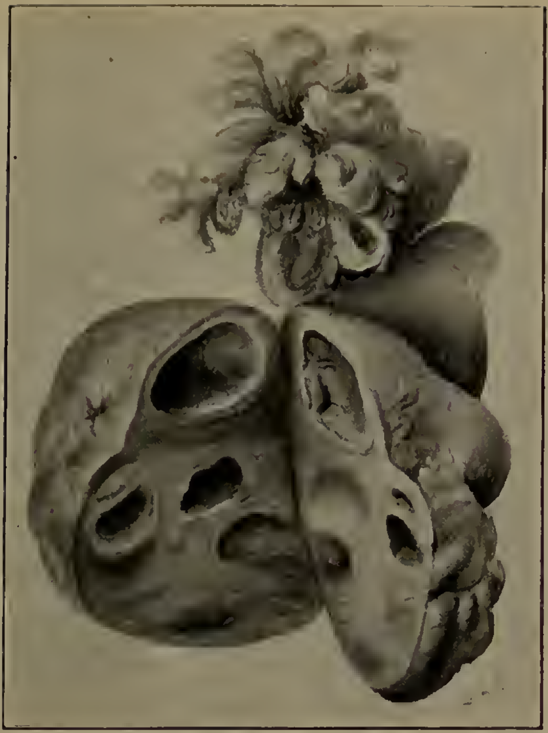


ECTOPIC GESTATION. (AUTHOR.)

The sac was adherent to the intestines. The fœtus was free in the abdominal cavity, and was found at operation under the diaphragm at the left side. The sac is open. The surface with adhesions is not seen.

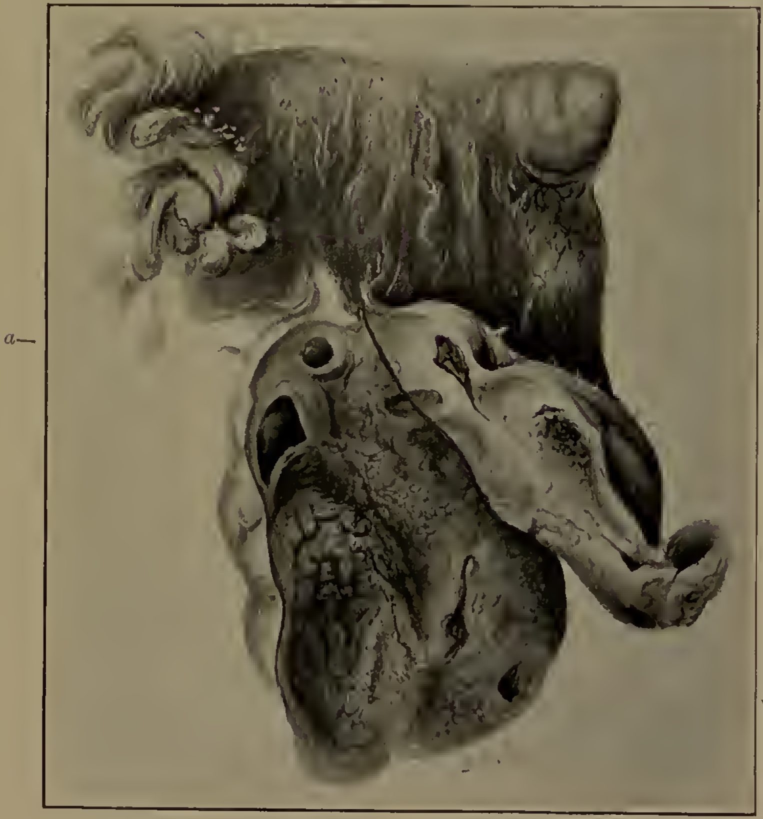
[*To face p.* 716.

PLATE LXXX.



Section of Cystic Ovaritis of Ovary, Sclerotic and Cystic Degeneration, with Thickened Fallopian Tube: Fimbriæ Normal. (Author.)

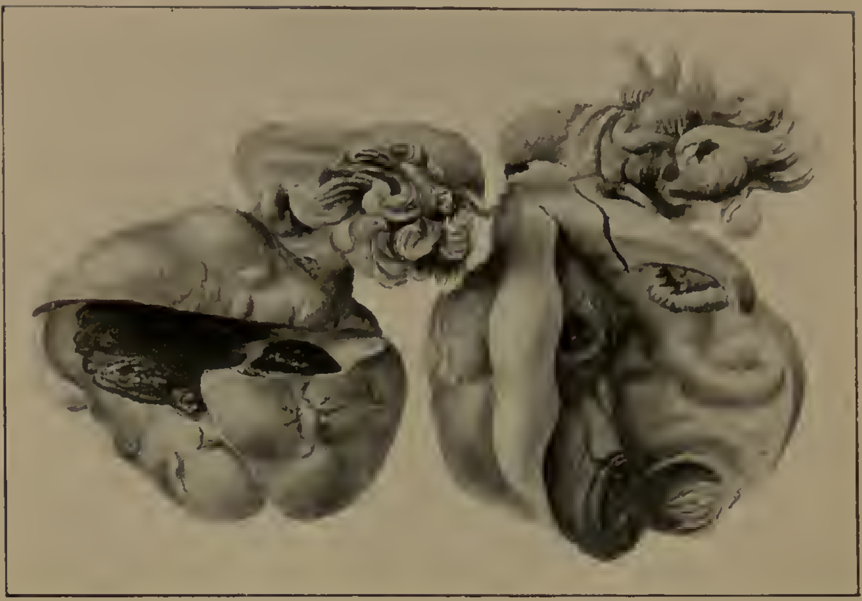
PLATE LXXXI.



Section of Hydrocystic and Sclerosed Ovary. Adhesions on the Enlarged Fallopian Tube and Accessory Ostia with Small Pedunculated Cyst of Morgagni (*a*).

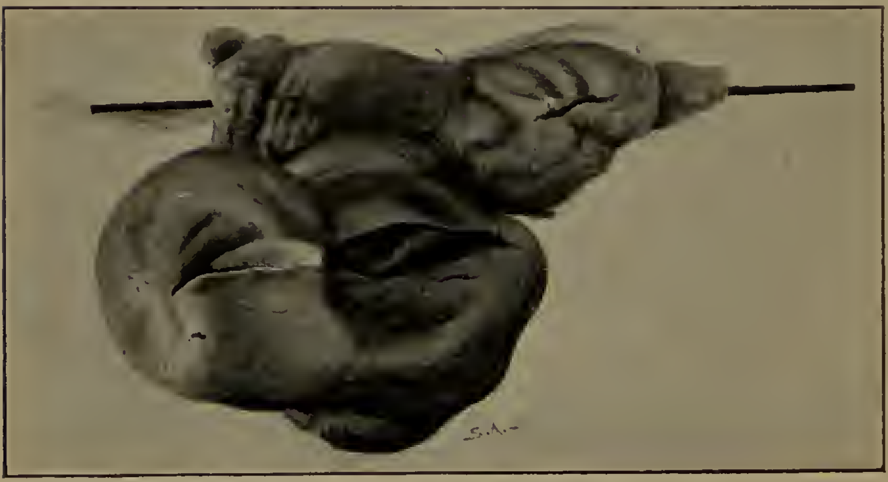
[*To face p.* 718.

PLATE LXXXII.



Ovaries, showing in the Right a Cyst with Coagulum; in the Left, Old and Recent Corpora Lutea.

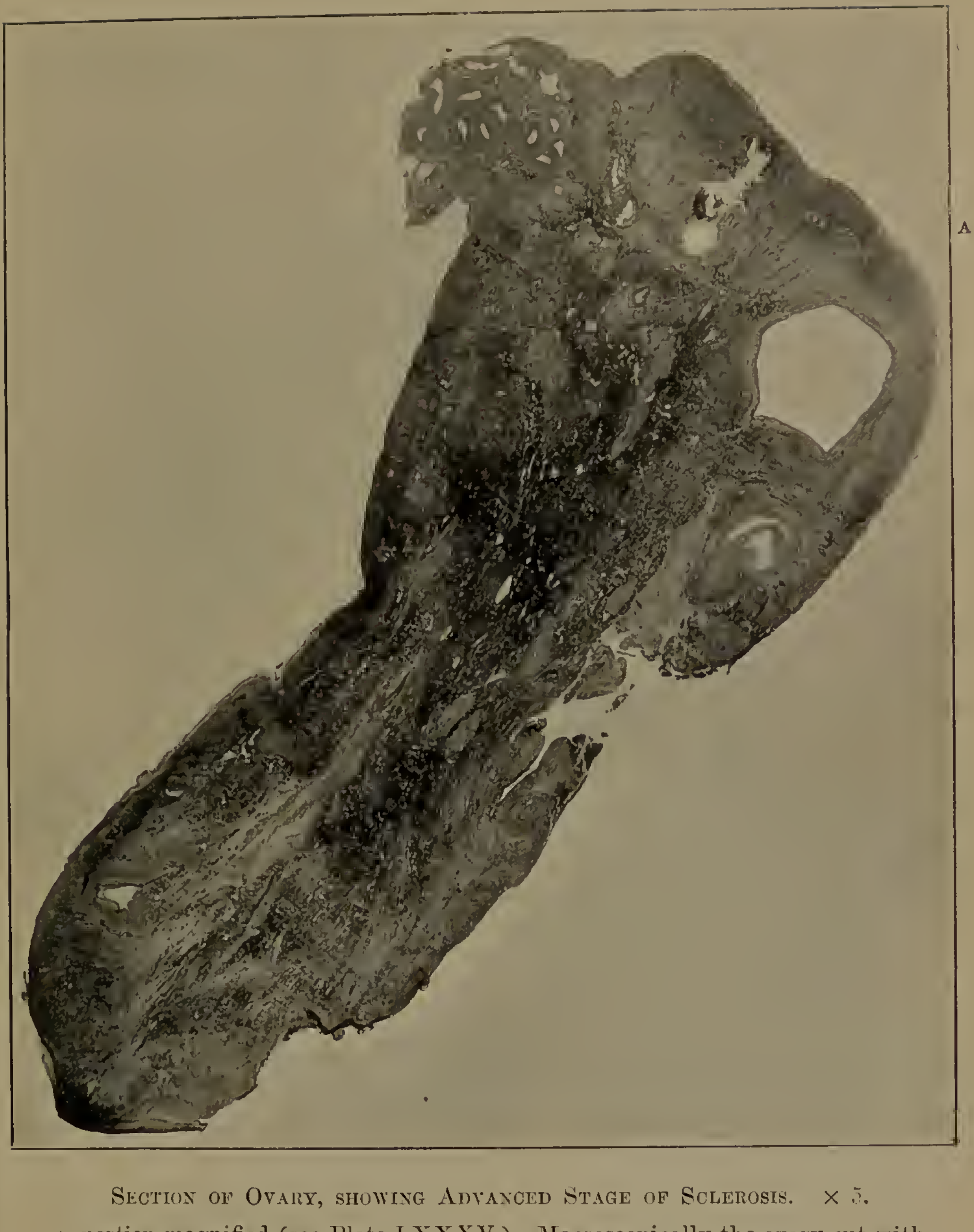
PLATE LXXXIII.



Bilocular Cystic Ovary with Fallopian Tube.

[*To face p.* 719.

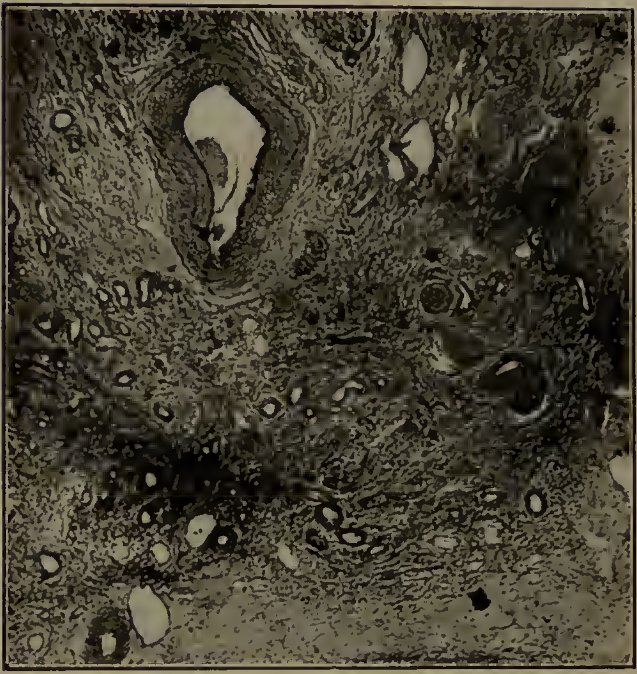
PLATE LXXXIV.



Section of Ovary, showing Advanced Stage of Sclerosis. × 5.

A, portion magnified (see Plate LXXXV.). Macroscopically the ovary cut with a fleshy appearance and without showing any cystic cavities, the cortex having a fibrous feel. Under a high power the section presents a general fibrous appearance, the corpora lutea and follicles are obliterated, some very small cavities, the contracted remains of cysts are scattered here and there throughout the fibrous material and connective tissue elements. Some few bloodvessels are seen with hypertrophied walls (see over page). One small cyst cavity denuded of epithelium is present. In this case the Fallopian tube was adherent to this ovary, and the parenchymatous changes in its walls obliterated the lumen of the tube. [*To face p.* 720.

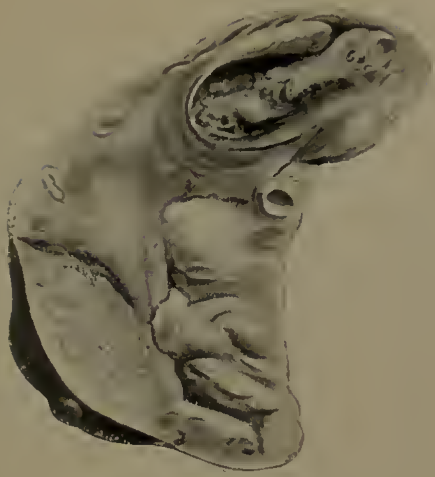
PLATE LXXXV.



Section from Ovary (Plate LXXXIV.), showing Fibrous Formation and Minute Cyst Cavities; a Thickened Vessel is seen in the Field near the Margin.

[*To face p.* 721.

PLATE LXXXVI.



Macroscopical Appearance of an Œdematous and Sclerosed Ovary, with Thickened Capsule and some Small Cystic Cavities in the Cortex.

The vessels were in most part obliterated. There was a blood cyst at one pole. The ovary was one removed for persistent ovarian dysmenorrhœa. The other ovary was resected.

PLATE LXXXVII.

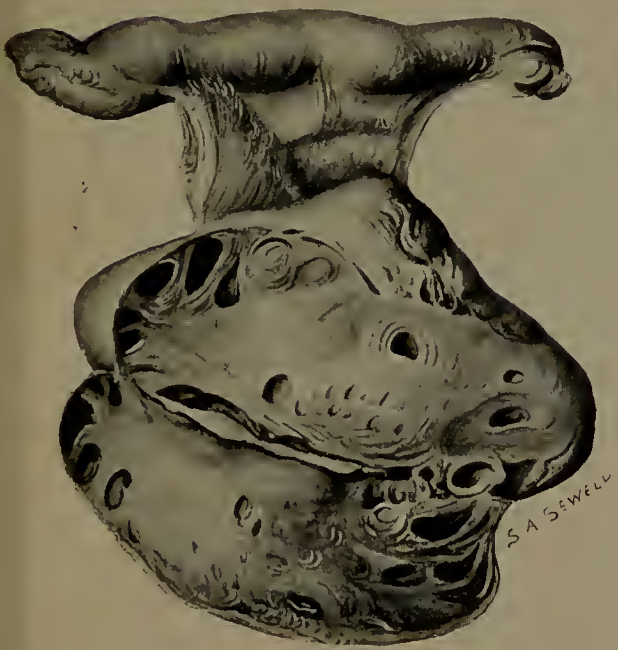
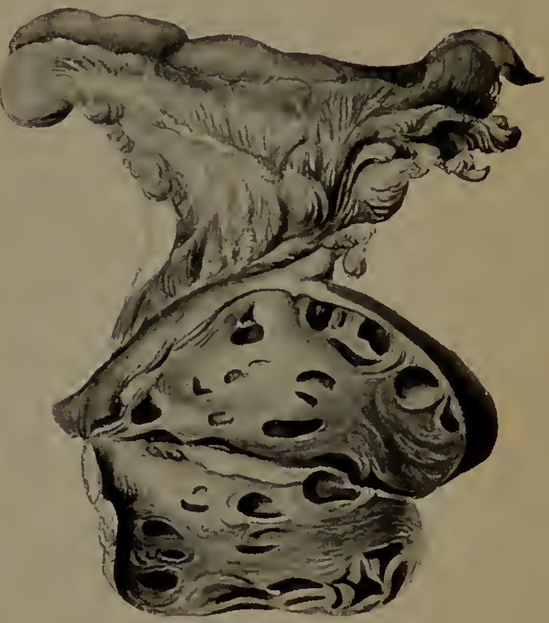


PLATE LXXXVIII.

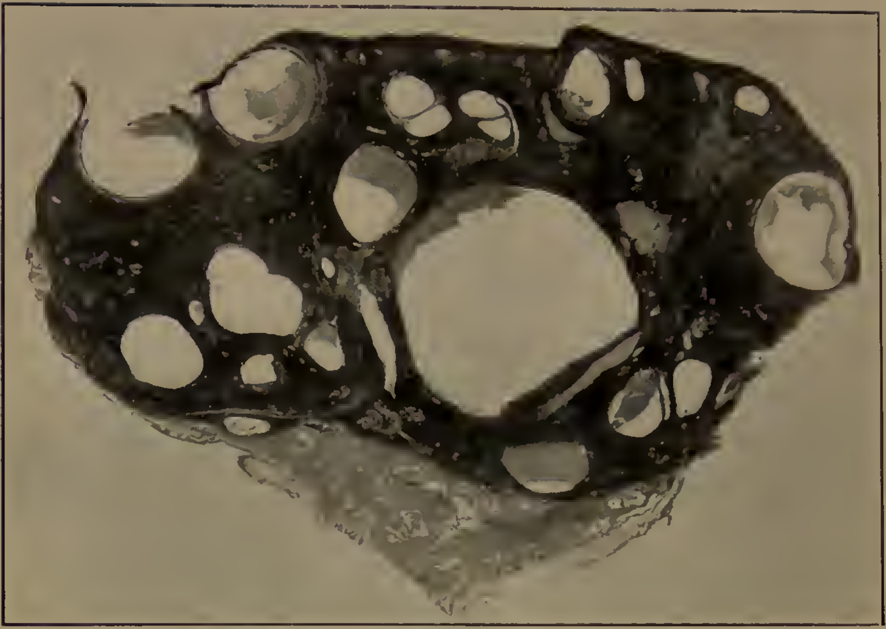


Macroscopical Appearances of Sclerosed and Cystic Ovaries, with Nodular Salpingitis.

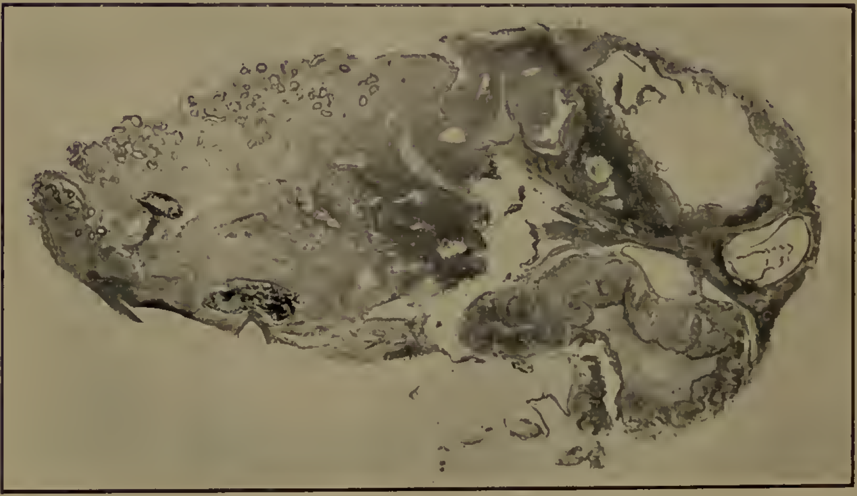
Removed from a patient, who had suffered for years from violent adnexal pain, dysmenorrhœa, and recently from menorrhagia, with symptoms of disordered mentalization during the catamenia.

[*To face p.* 722.

PLATE LXXXIX.



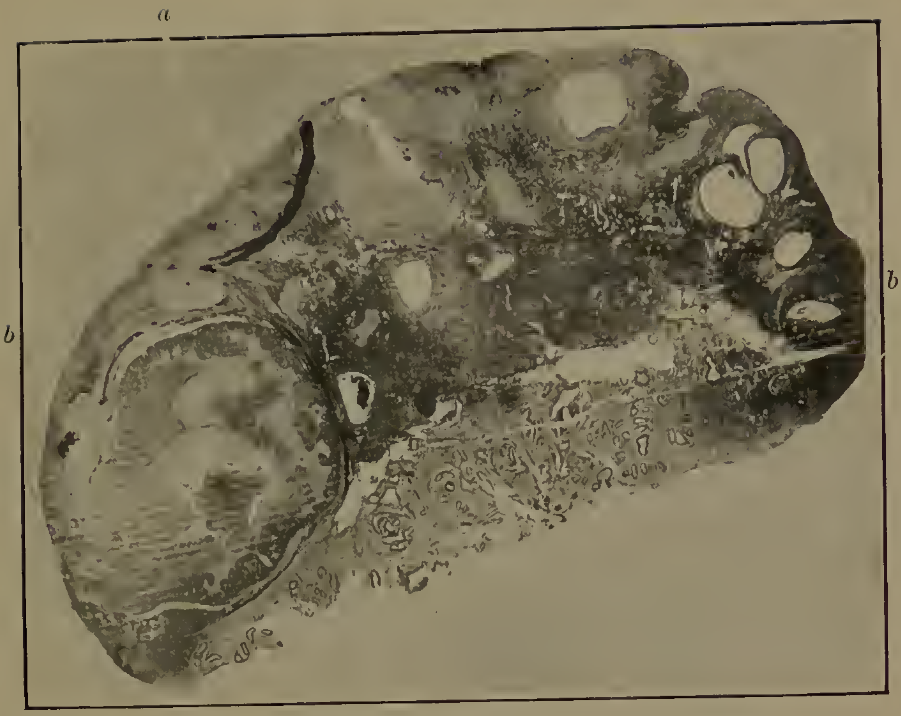
Natural size of mounted section, 4 × 2½ cm.



Natural size of mounted section, 3 cm. 7 m. × 1 cm. 8 m.

Photographs of Transverse Sections of Sclerosed and Cirrhotic Ovaries, in which there has been Interstitial Fibrosis followed by Obliteration of the Corpora Lutea and Follicles, with Cystic Degeneration arising from both of the latter.

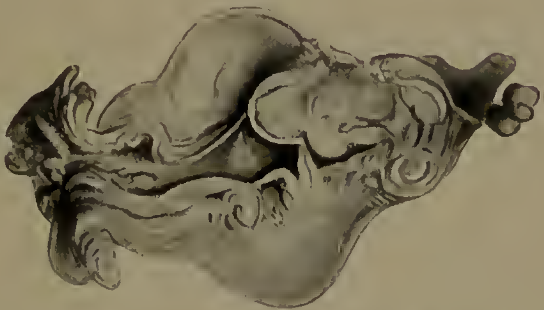
PLATE XC.



SECTION OF SCLEROSED AND CYSTIC OVARY. (AUTHOR.)

4½ cm. × 2½—natural size of the mounted section (see Plate XCII.).

PLATE XCI.



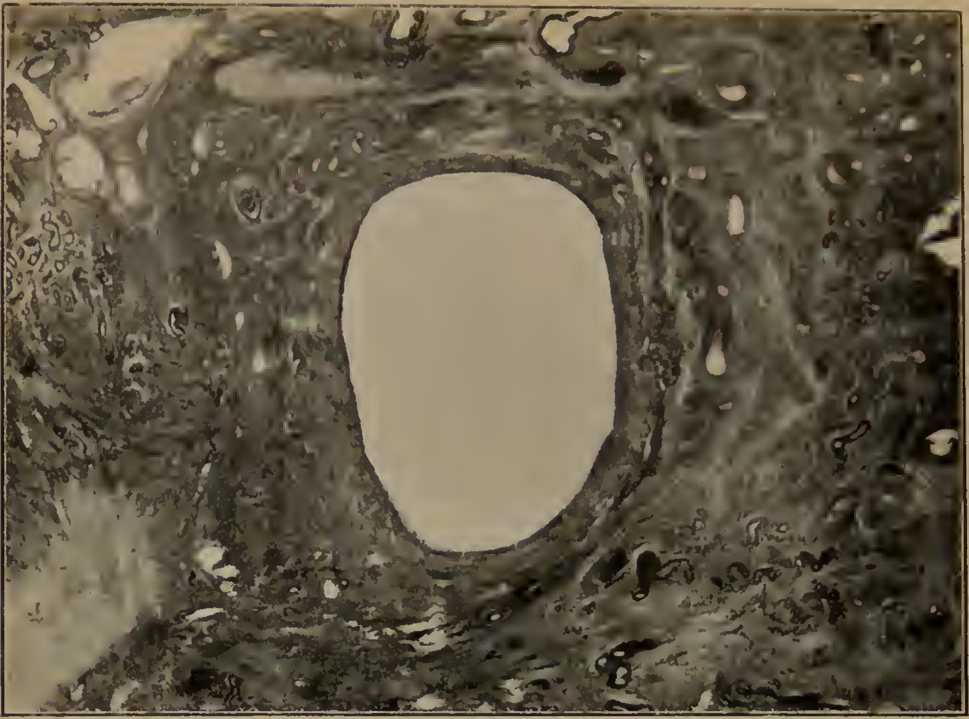
DIVIDED NODULAR FALLOPIAN TUBE, REMOVED WITH THE SAME OVARY. (AUTHOR.)

The patient, aged 34, married eleven years; five pregnancies, no miscarriages; last labour thirteen months since. For five years had had constant pain in the left side and left leg. Of late had been unable to walk, and her general health had failed. The ovary which was removed presented through its entire extent sclerotic degeneration. Dr. Cuthbert Lockyer examined the specimen.

The capsule was thickened. The stroma was studded all through with cystic cavities, the remains of Graäfian follicles and corpora lutea. Areas of modified fibrous tissue represented the latter; there were round-celled exudation of the stroma and thickening of the tunica albuginea. The walls of the vessels were seen greatly thickened, their appearance somewhat similar to the condition seen in arterio-capillary fibrosis of the kidney. There were no adhesions of ovary or tube.

The tube was typically nodular in appearance, and measures 4 cms.; its uterine cut end is normal in size, its proximal end, 1 cm.; it then enlarges and becomes very tortuous, its maximum circumference measuring 3 cms. It was split down the middle along the whole of its dilated part, and on section all the constituent parts of its walls were thickened, the muscular layer swollen and the plicæ œdematous, while the fimbriæ were fleshy and also swollen. There were no areas of caseation.

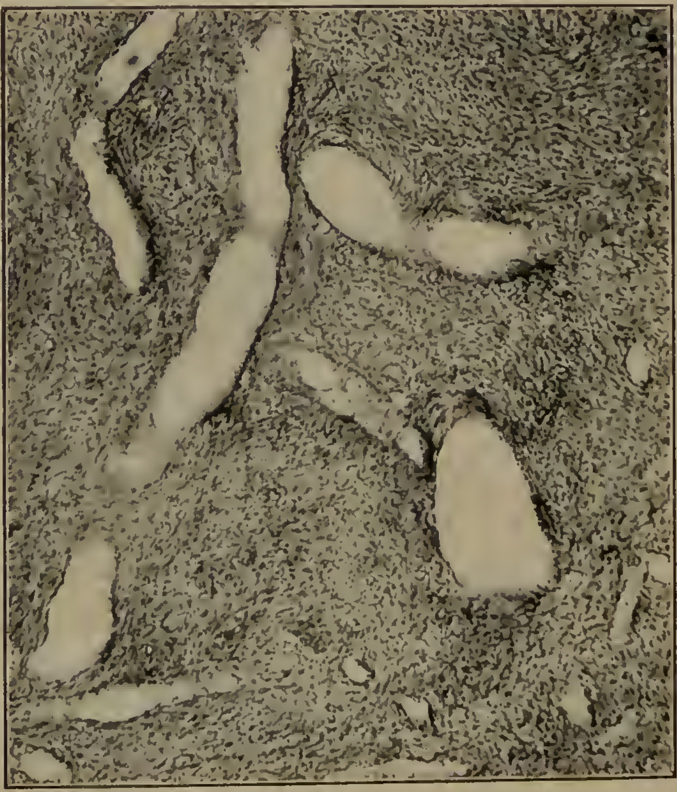
PLATE XCII.



Microscopical Appearances, from Centre of Section, *b—b*, Plate XC. × 90. (Author.)

Showing the annular arrangement of the fibrous elements around the follicle which is denuded of epithelium, with surrounding fibrotic and hardened connective tissue elements.

PLATE XCIII.

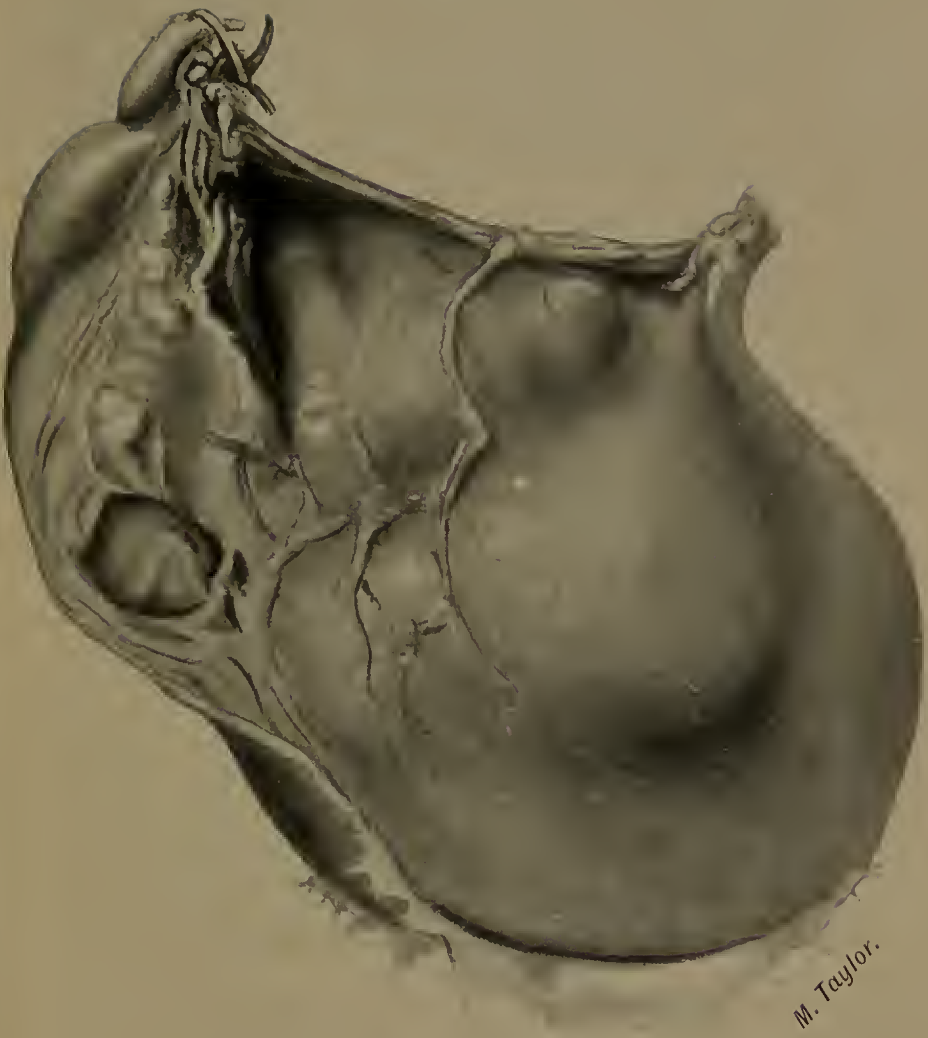


Microscopical Appearances—Cortex of Plate XC. (*a*). × 110.

Interstitial fibrosis and cystic degeneration in the sclerosed area.

[*To face p.* 723.

PLATE XCIV.

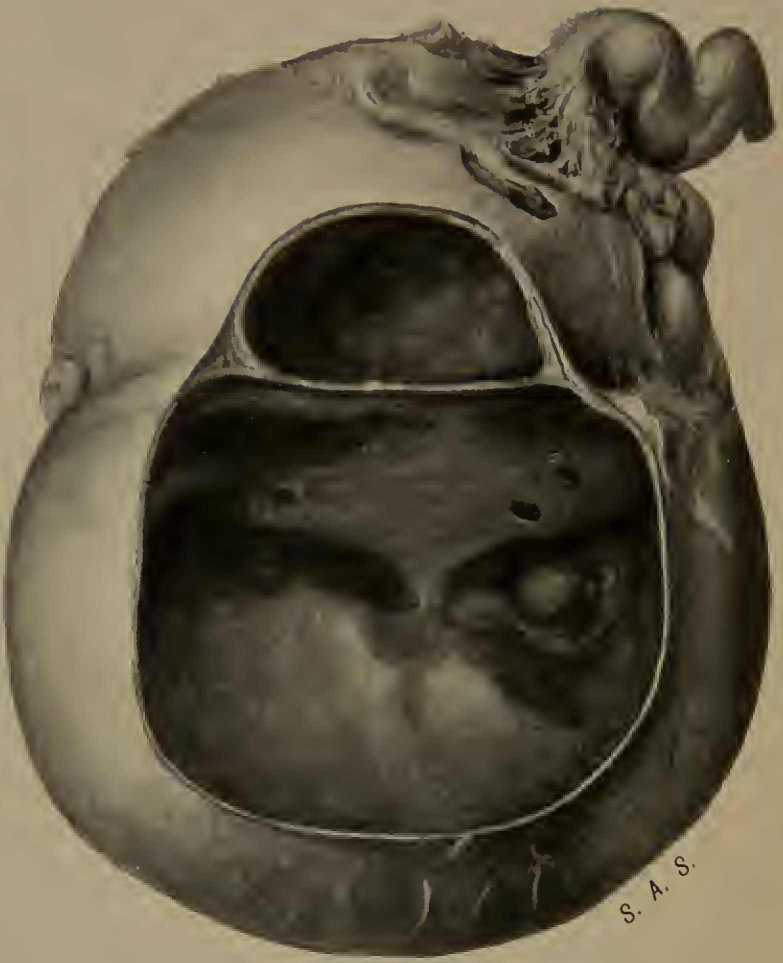


Ovarian Blood Sac. (See also Plate XCVIII.)

Natural size. Drawn after removal of the tumour and before the blood was evacuated.

[*To face p.* 726.

PLATE XCV.

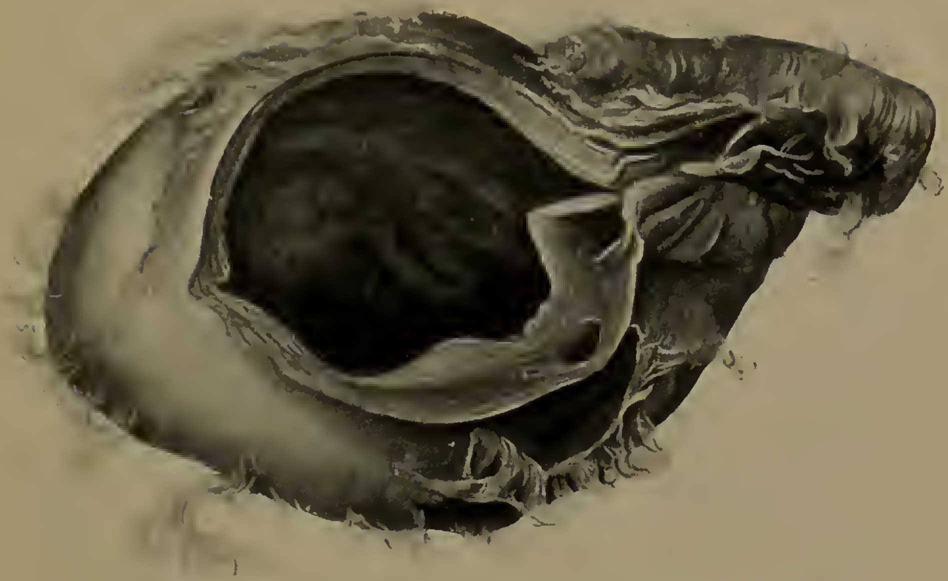


INTERIOR OF SAME SAC (PLATE XCIV.).

Drawn after removal of the blood and preparation of the specimen. The bilocular nature of the cyst is shown, with the Fallopian tube attached to the summit of the sac, not opening into it.

[*To face p.* 727.

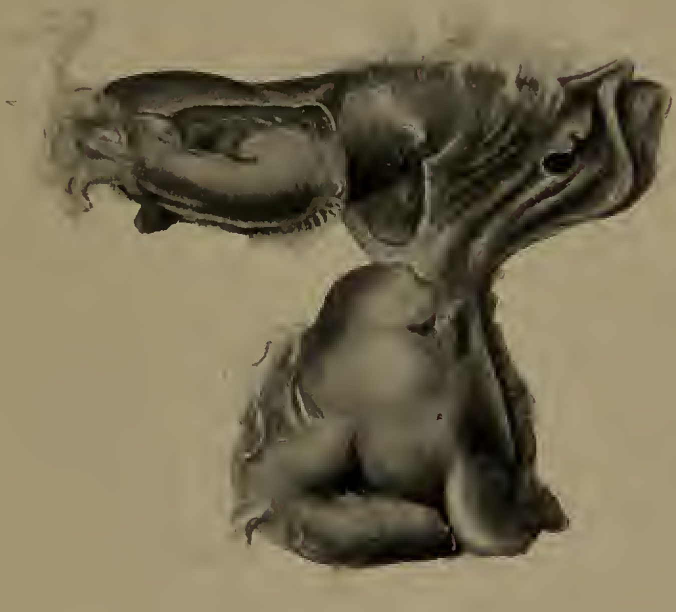
PLATE XCVI.



Large Right Ovarian Pus Sac with the Portion of the Tube opening into the Sac. (Author.)

Both ovary and tube were embedded in adhesions, the sac wall being lined with swollen papillary granulations.

PLATE XCVII.



Smaller, Left Cystic and Gyromatous Ovary with Sclerosed Capsule with the Cystic Tube removed from the same Patient. (Author.)

See other side for abstract of the Histological Report of these adnexa.

[*To face p.* 728.

Right and Left Salpingo-Oöphoritis, with Pus Cysts of Ovaries.

The patient from whom the adnexa (Plates XCVI., XCVII.) were removed had been married for twelve years. She had had two children at full term, and two miscarriages. Her last pregnancy was nine years since. Uterine hæmorrage commenced about two years ago, and occasionally was very excessive. It was associated with great pain in the left side and over the sacrum. Offensive clots were passed occasionally, and, after these, watery discharges. Seven years previously the uterus had been curetted. At the time of operation she was very weak, and walked with difficulty. At operation, a cyst about the size of an orange was found in Douglas' space at the right side, with a very enlarged and dilated oviduct, and at the left side an enlarged and diseased ovary with a correspondingly thickened tube. At both sides the adnexa were buried in plastic lymph. The pus sac ruptured on the point of delivery, but very little pus escaped into the abdominal cavity. After removal of the adnexa the pelvis was freely mopped out with swabs wet with formalin solution. The tubes had the appearance of tuberculous salpingitis, and the associated pus cyst made me suspicious that the trouble might be of tuberculous nature.

Abstract of Histological Report on the Adnexa (Plates XCVI., XCVII.).

'**The Tubes.***—In the large tube (the one attached to the ovarian cyst), the mucosa is nearly entirely replaced by granulations, only a few columnar tubes being left to represent plicæ. Under the peritoneum are seen granulomatous-looking areas, circular and oval, consisting of round-celled infiltration surrounded by a fibrous capsule. The entire musculo-fibrous wall is infiltrated, and the vessels contained in it have thickened walls. No giant-cells are seen.

'The smaller tube shows plicæ, which are swollen by leucocytic infiltration; the mucosa between the plicæ is also infiltrated in like manner. There are no subperitoneal deposits, but no doubt this tube shows the same process as that seen in the larger one, only in a much earlier stage. No giant-cells are seen. It has a pervious abdominal ostium, near to which is a cyst the size of a filbert-nut; this proceeds from the lower attached margin of the tube. The latter is thickened, but to a far less degree than its fellow.'

'**The Ovaries.**—The cyst measures 7 cm. in long diameter, and 5 cm. in the vertical. Opening into its upper and inner aspect is the tube: the point of entrance is indicated by a bristle. The tube is much thickened, measuring 2 cm. in thickness at its cut extremity. The cyst-wall is studded by what, to the naked eye, look like small yellow papillomata, about the size of a pin's head. The cyst-wall contains loculi, probably the remains of Graäfian follicles, and it varies considerably in thickness, from 1 cm. to 3 cm. Externally are seen ragged adhesions of organized lymph.

'The smaller ovary measures 3·5 cm. in the vertical, and 3 cm. in the transverse diameter. Its surface is puckered, and covered by organized lymph. There was cystic degeneration, and gyromatous changes were present throughout the ovary.'

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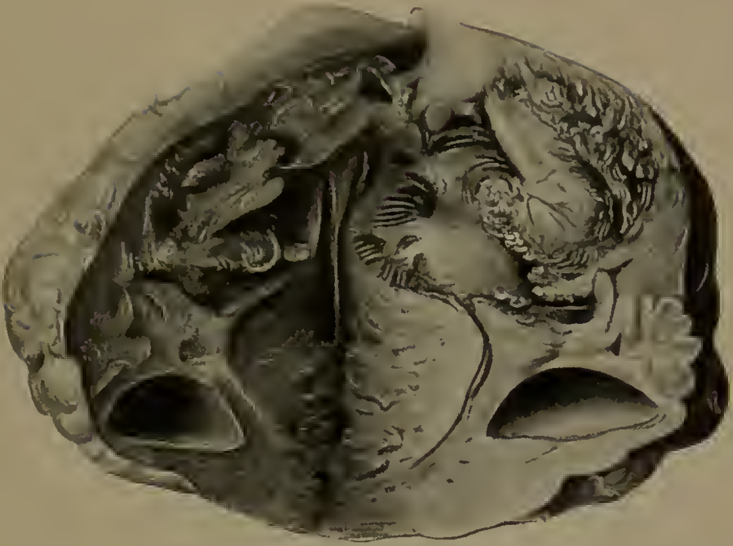
* See Plates LII., LIII.

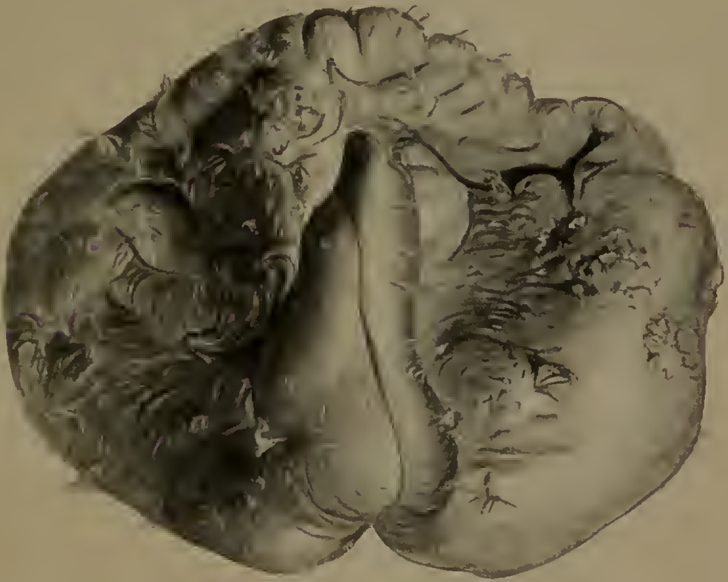
PLATE XCVIII.



Pyo-cystic Ovary bisected; removed by Abdominal Cœliotomy. (Author.)

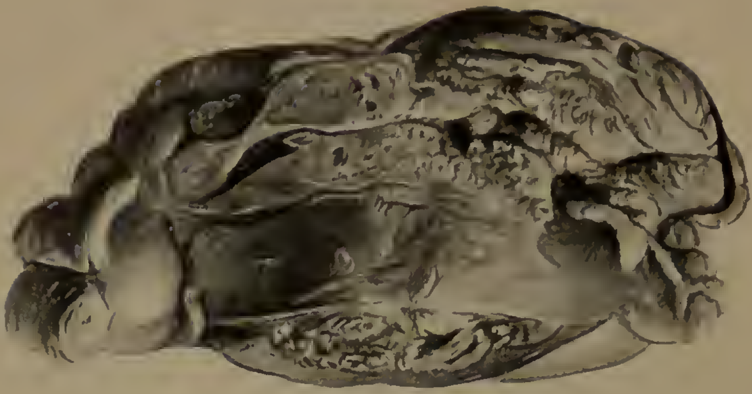
The adnexa were embedded in adhesions. The tube was incorporated with the wall of the sac; not opening into it.

PLATE XCIX.



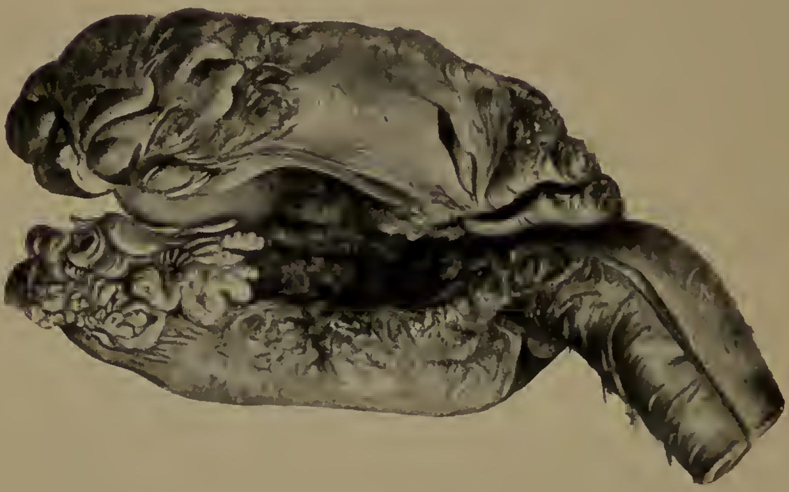
External Surface of same Adnexa, showing the Adhesions and Incorporated Tube.

PLATE C.



Tubo-Ovarian Pyo-cyst—Sac opened to show Interior—Tube opening into the Sac—Abdominal Cœliotomy. (Author.)

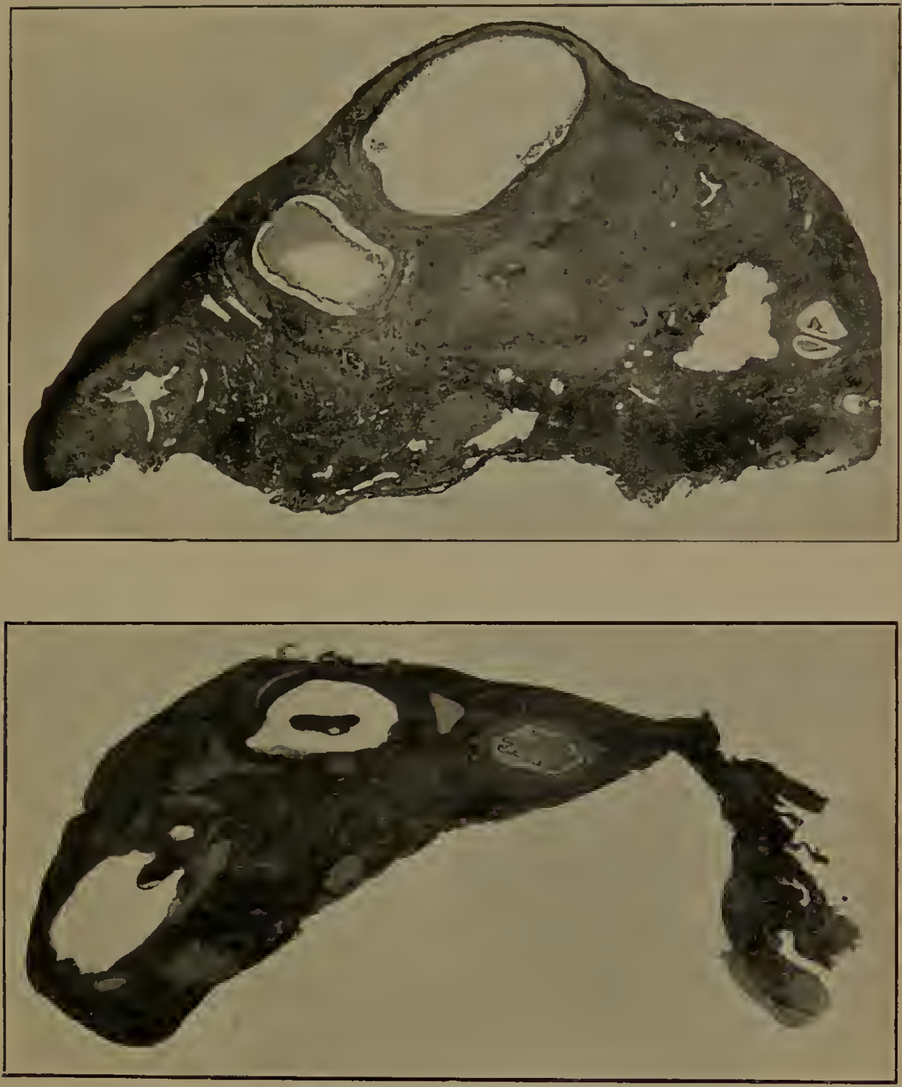
PLATE CI.



External Surface of the Ovary—the Adherent Tube has been dissected out from the Bed of Adhesions.

[*To face p.* 729.

PLATE CII.

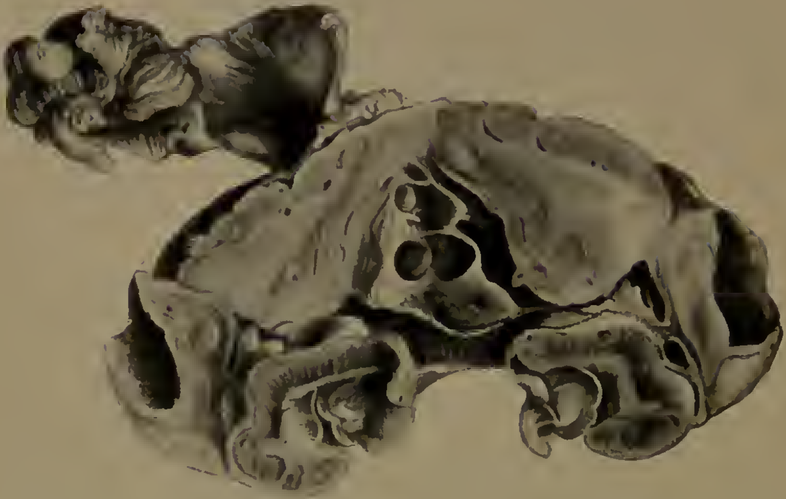


Sections of Resected Portions of Ovaries (× 2) removed from Patients at the Same Time that the Uterus was Ventro-suspended.

The albuginea was thickened; there was sclerosis of the cortex with cystic degeneration. The deeper stroma was found cellular, the follicles atresic and degenerate, and reduced in numbers. There were corpora lutea in all stages of evolution, some cystic with an excess of lutein cells in their walls. Severe adnexal pain and dysmenorrhœa were added to the symptoms due to the retro-displacement (Cuthbert Lockyer's Report).

[*To face p.* 730.

PLATE CIII.

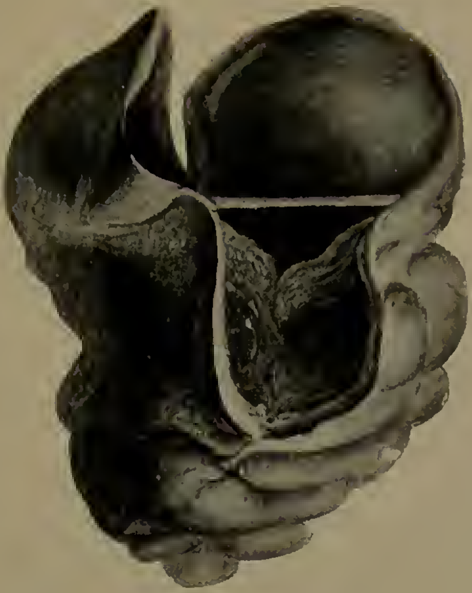


MACROSCOPICAL APPEARANCES OF A CYSTIC AND SCLEROSED OVARY WITH PORTION OF TUBE.

This ovary was removed from a patient (unmarried) who suffered for years from adnexal pain and severe dysmenorrhœa. The other ovary had been removed two years previously. It was a large cystic ovary. The uterus, which was retroflexed, was at the same time ventro-suspended.

[*To face p.* 731.

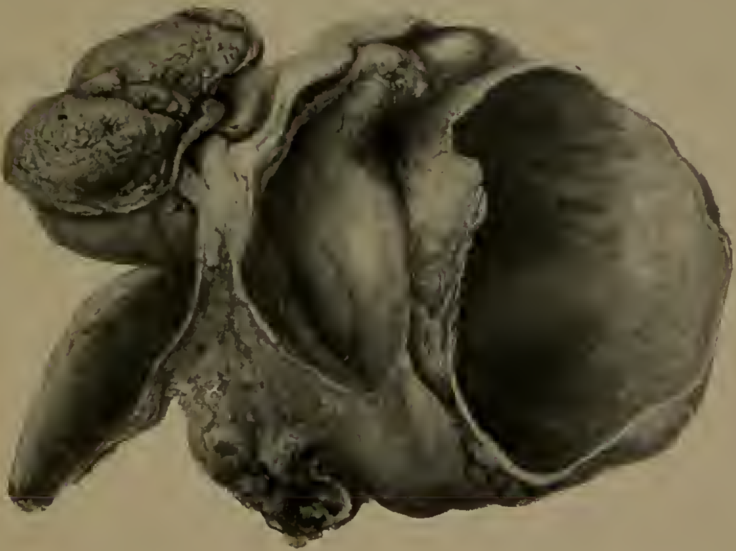
PLATE CIV.



First Operation:—Right Cystic Ovary removed by Cœliotomy from a Patient suffering from Severe Anorexia and Constant Vomiting, with Complete Relief from the Symptoms.

The left ovary was reseated at the same time.

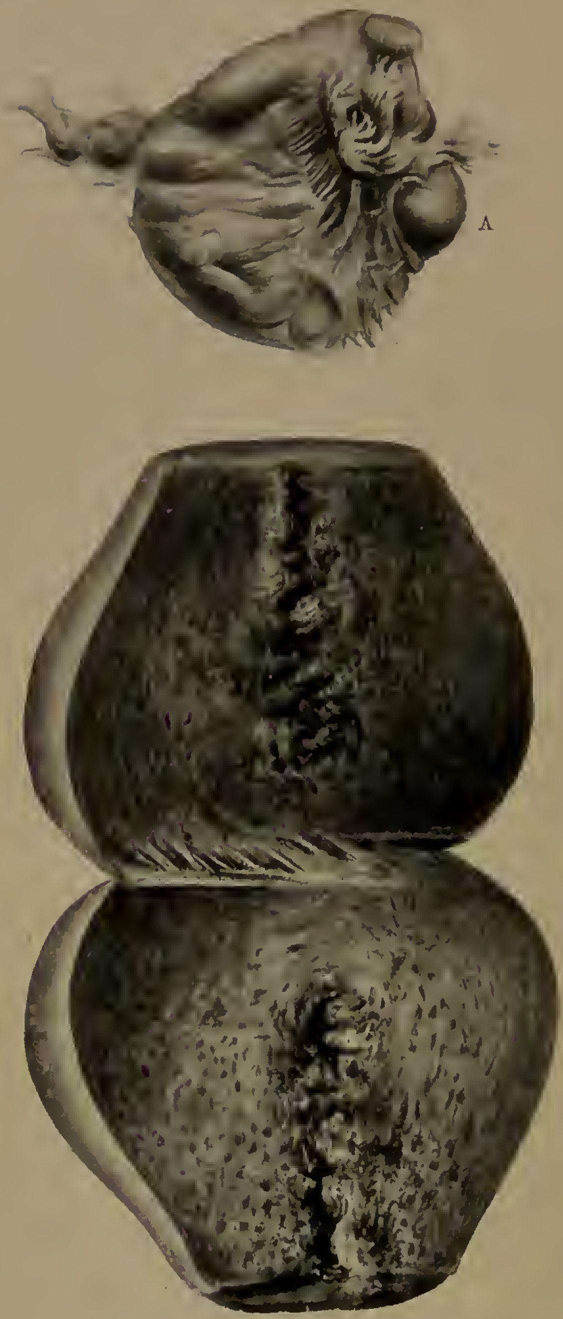
PLATE CV.



Second Operation:—The Left Ovary containing Blood Cyst and Dual Cyst in the Broad Ligament removed One Year subsequently to the Previous Operation, and for similar Symptoms, from the same Patient. (*See over.*)

[*To face p.* 736.

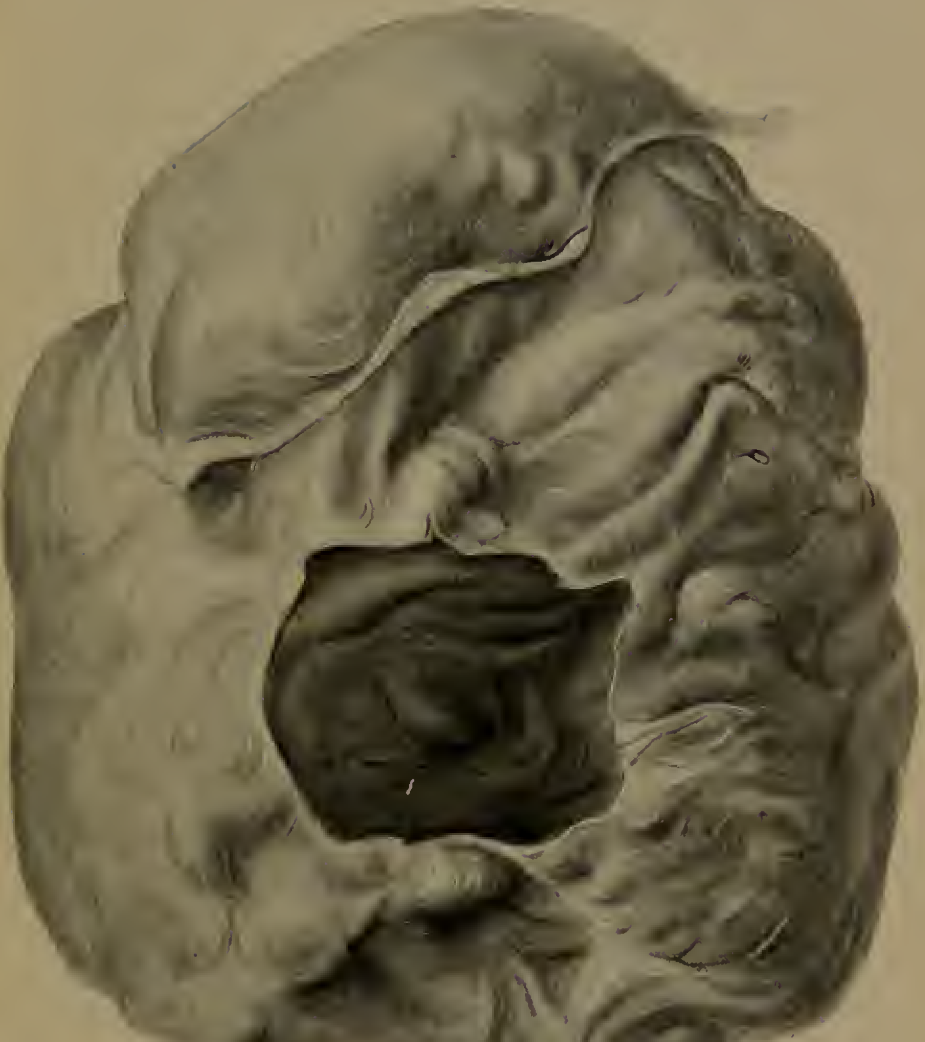
PLATE CVI.



Third Operation:—Uterus and Broad Ligament Cyst of same Patient, from which the Ovaries (shown in Plates CIV., CV.) were removed; Operation Two Years subsequently.

The cyst A was found between the layers of the broad ligament. The uterus was adenomatous, and the canal, with the endometrium, presented the appearance shown in the drawing. The hysterectomy was performed for persistent uterus hæmorrhage. [*To face p.* 737.

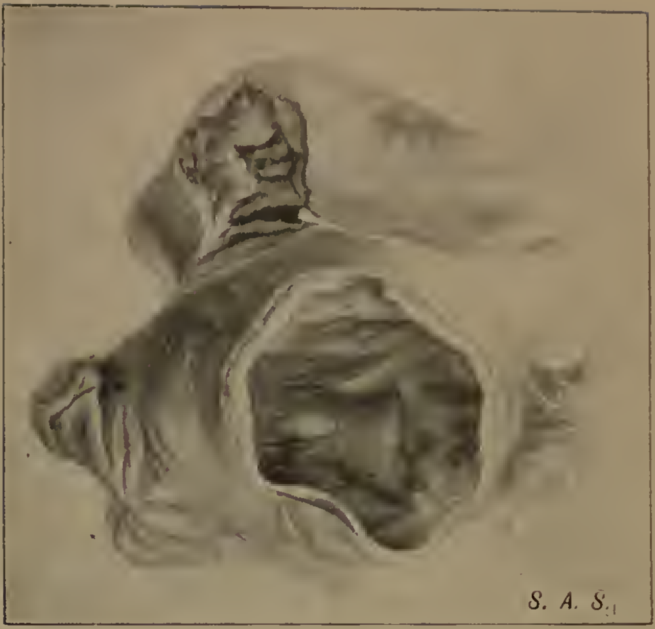
PLATE CVII.



Broad Ligament Cyst. (J. Taylor.)
Nat. size. Removed successfully by the vagina.

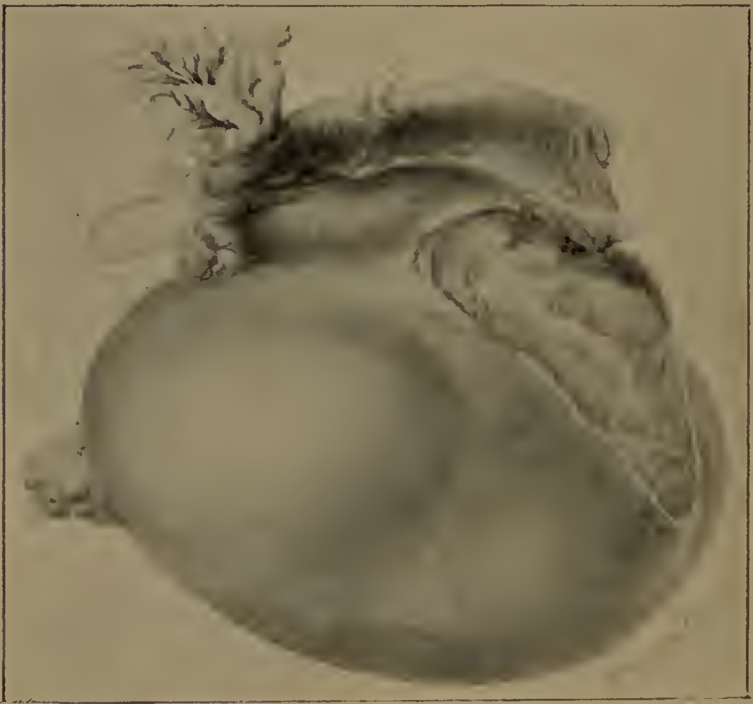
[*To face p.* 742.

PLATE CVIII.



Cyst of the Meso-salpinx, simulating an Ectopic Gestation Cyst. (Author.)

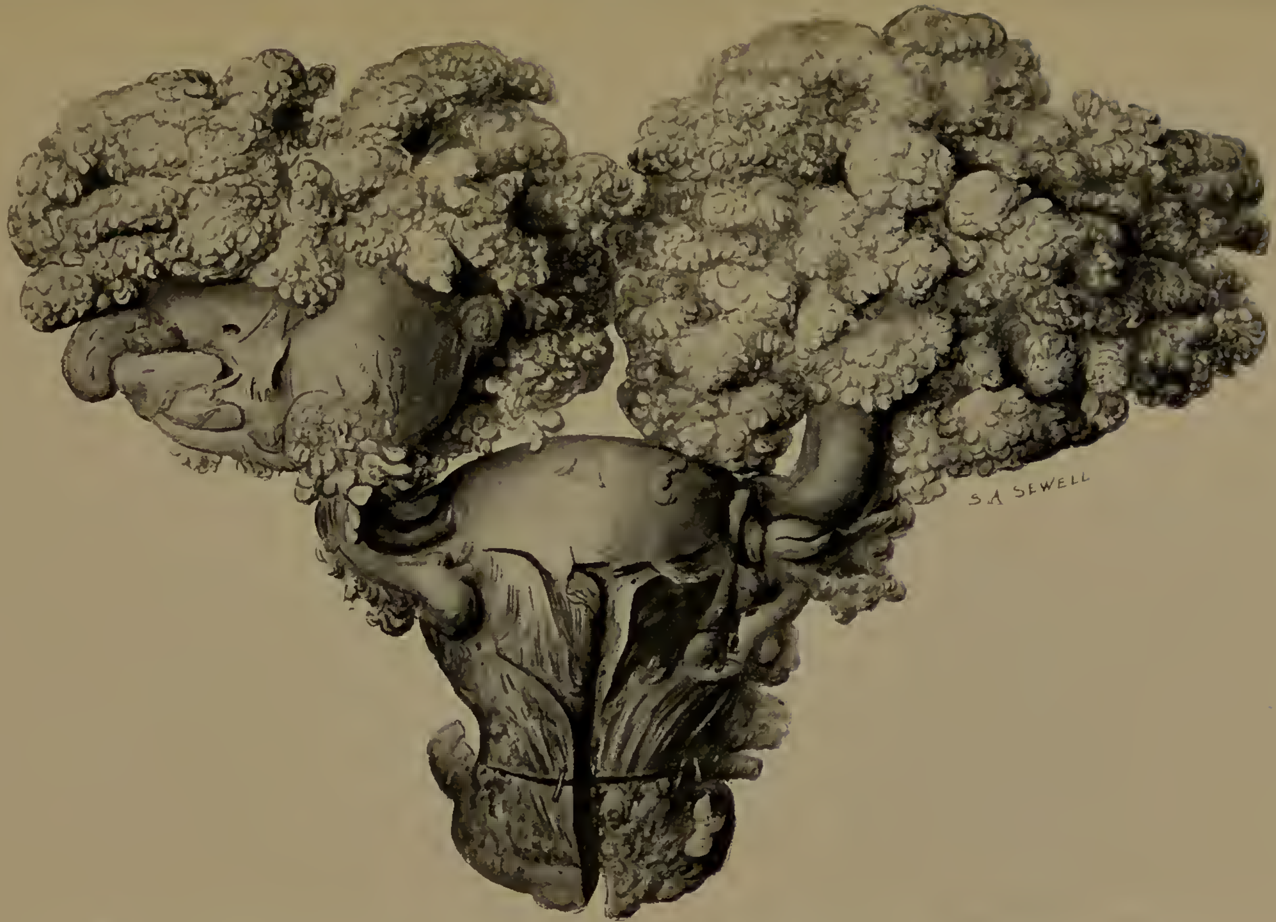
PLATE CIX.



Parovarian Cyst lying in Douglas's Pouch, simulating Retroversion on Uterus. (Author.)

[*To face p.* 743.

PLATE CX.



Specimen of Double Ovarian Papilloma and Cervical Carcinoma, with Associated Carcinoma of the Cervix Uteri.* (Gelston Atkins.)

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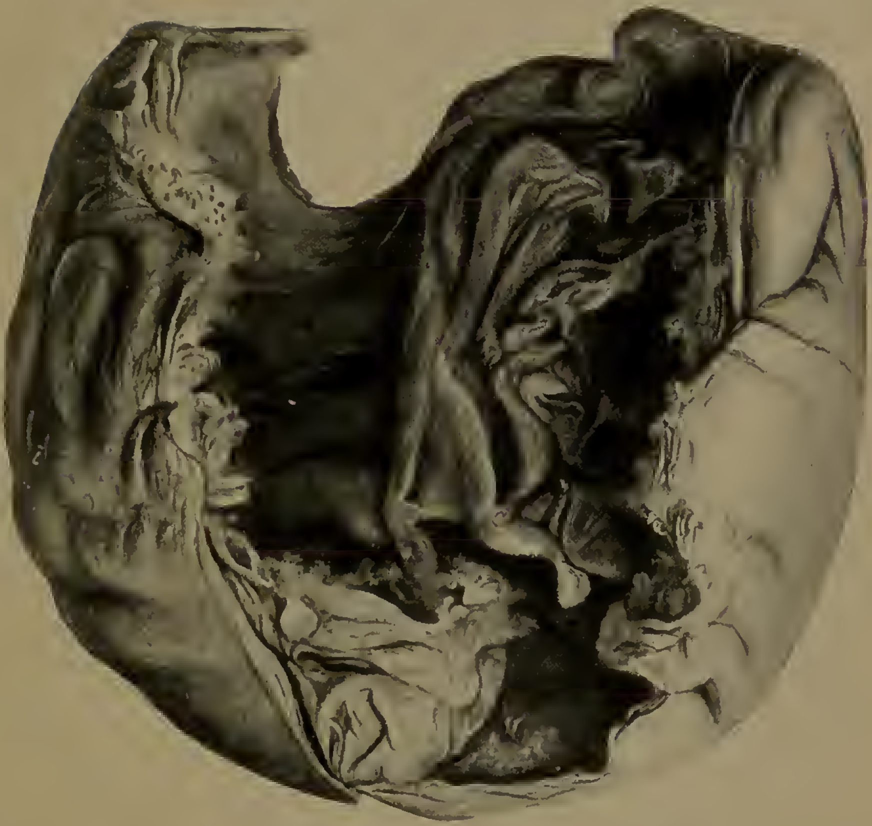
* *Brit. Gyn. Jour.*, 1904.

[*To face p.* 746.

PLATE CXI.

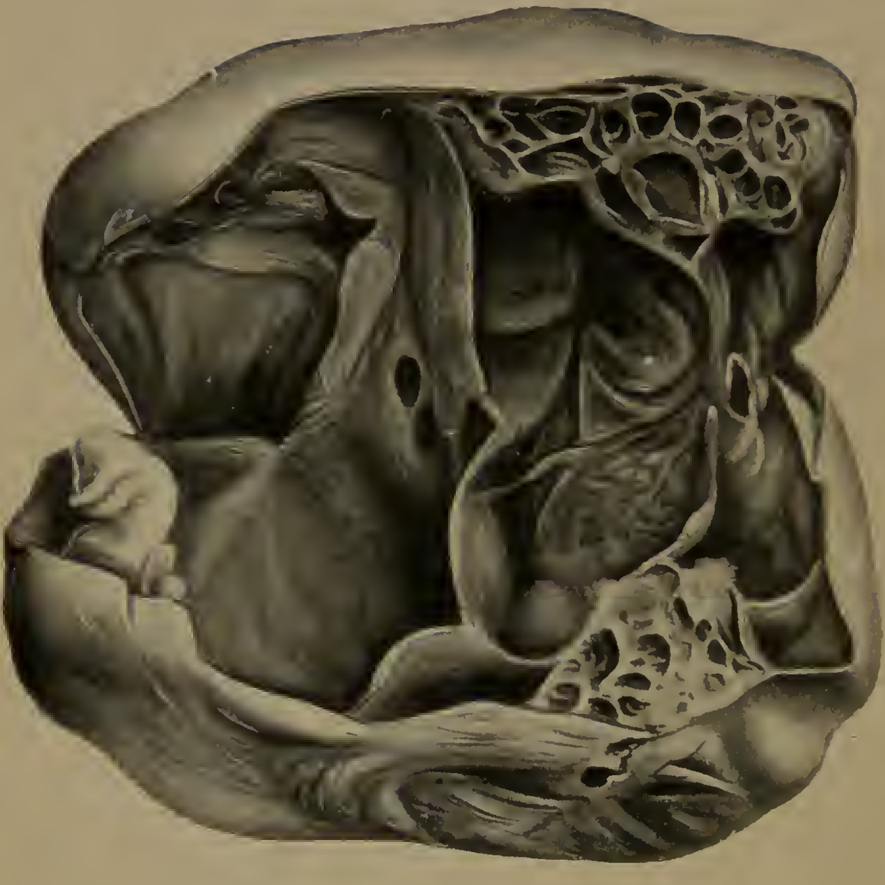


CYSTO-CARCINOMA OF THE OVARY.

Interior of carcinomatous ovary, removed with the other ovary and two large pedunculated myomata. Patient survived one year.

[*To face p.* 748.

PLATE CXII.

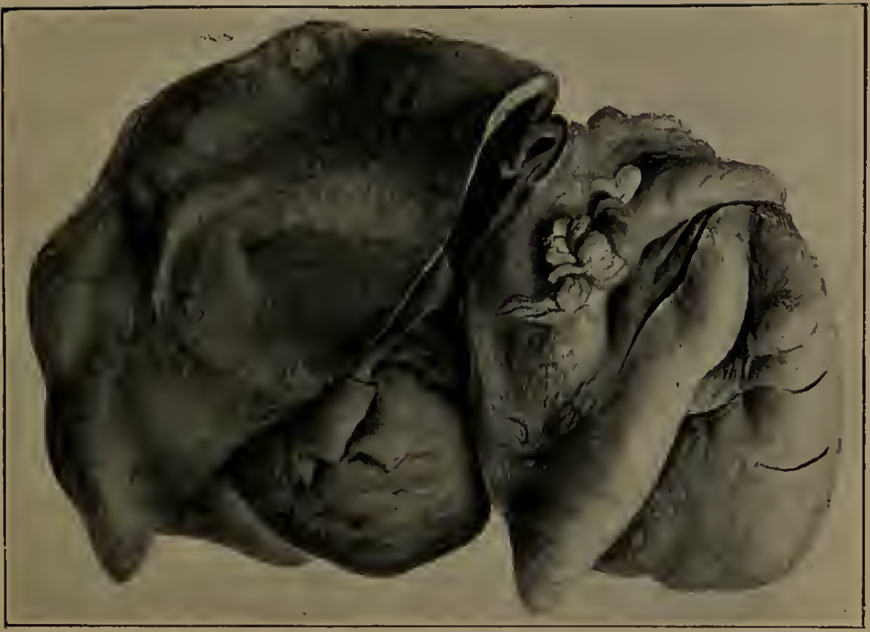


INTERIOR OF CYSTO-CARCINOMATOUS OVARY.

Removed from same patient as Plate CXI. ($\frac{2}{3}$ nat. size.)

[*To face p.* 749.

PLATE CXIII.

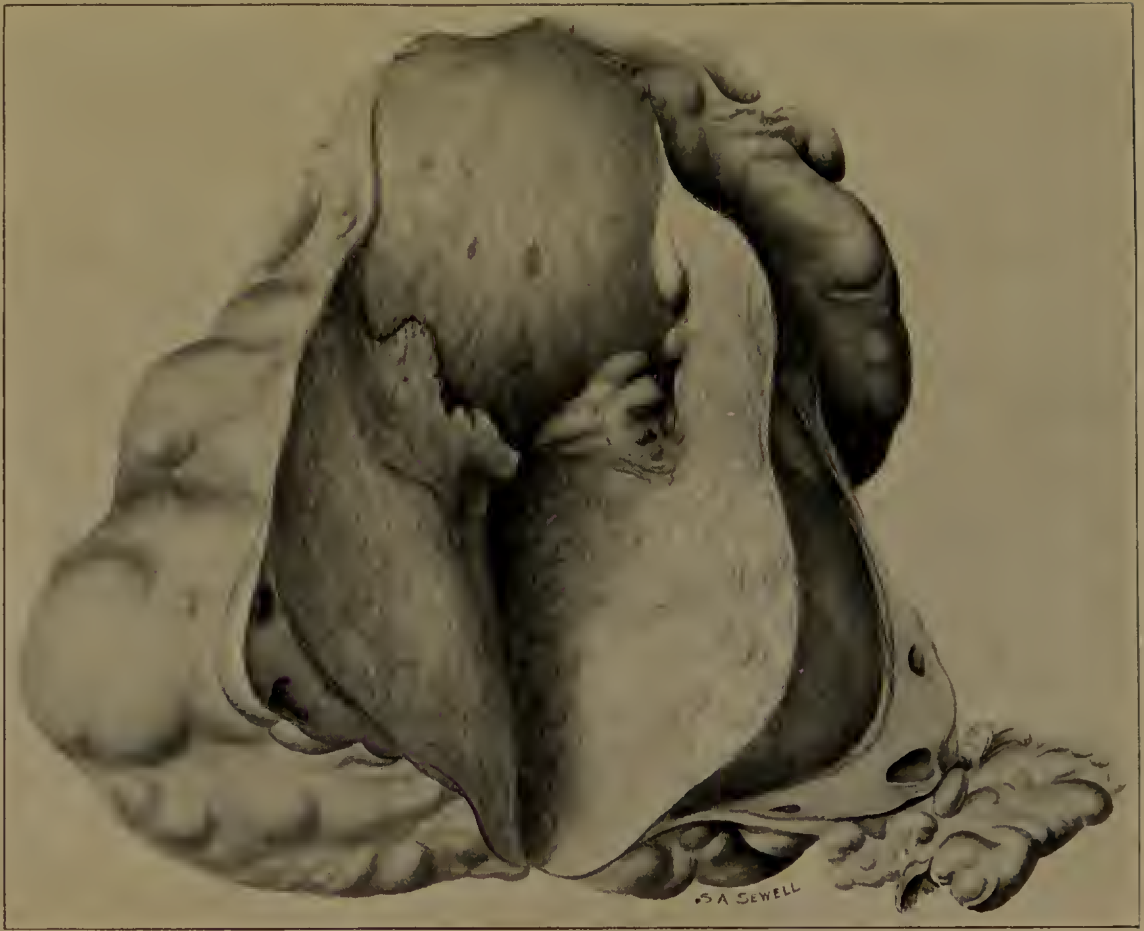


Solid Ovarian Adenoma with Cystoma, removed immediately after an Acute Attack of General Peritonitis. (Author.)

Pathological Report: 'A multilocular ovarian cyst, consisting chiefly of one large loculus, with imperfect septa. The whole specimen (after evacuation of the cystic fluid) is about the size of an adult head. The pedicle appears to have been twisted, and the surface of the specimen was universally adherent. The meso-salpinx is plastered to the cyst-wall, but the Fallopian tube in it is normal. The solid portion of this specimen has the structure of a simple multilocular adenoma of the ovary. The smaller spaces are lined with columnar epithelium, and the larger ones are filled with a colloid substance. There is no evidence of malignant disease.' (J. H. Targett.)

[*To face p.* 757.

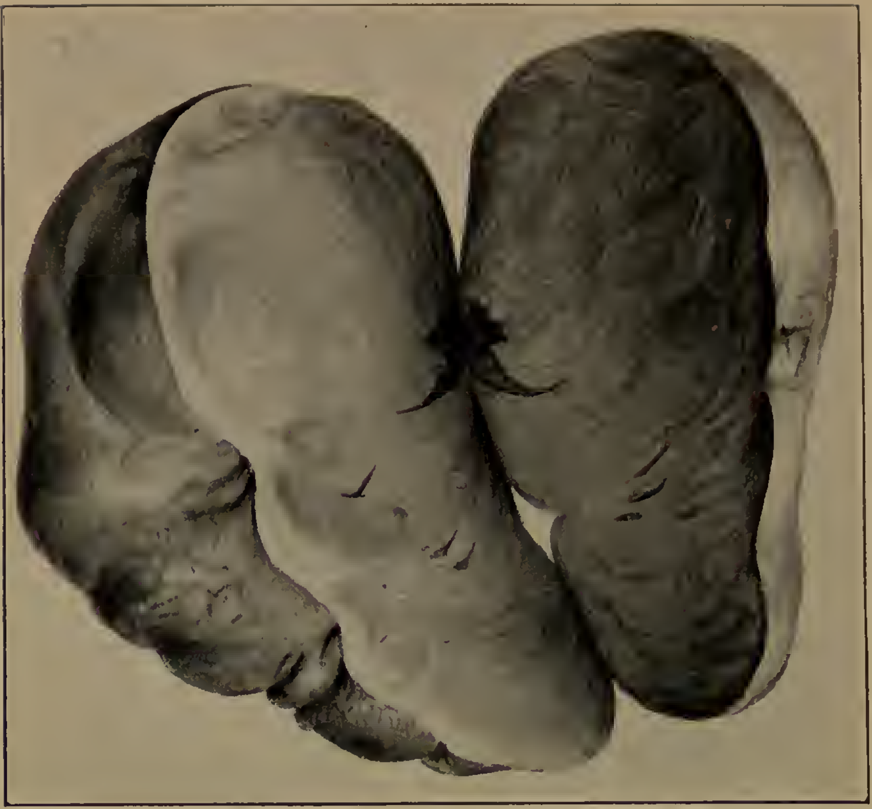
PLATE CXIV.



CYSTO-SARCOMA OF THE LEFT OVARY. (AUTHOR.)

The sarcomatous growth filled the pelvis, pushing the uterus out of it and to the right. When first seen and diagnosed as myoma of the uterus, the degeneration converting a portion of the tumour into a cyst had not occurred; ascites followed. The cyst was tapped and the mass removed. Recovery has been complete, and so far permanent. [*To face p.* 772.

PLATE CXV.



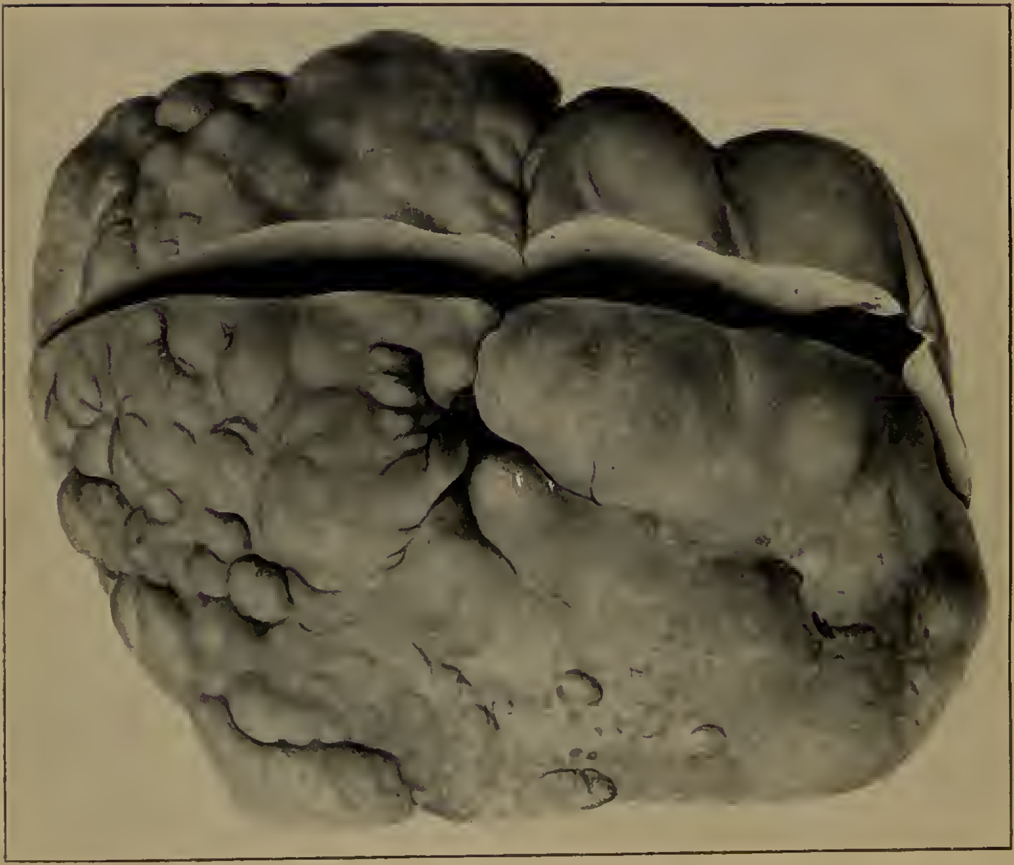
ADENO-FIBROMA OF THE OVARY. (AUTHOR.)

Removed from the same patient as the Scirrhus Carcinoma.

Reduced to $\frac{2}{3}$ nat. size.

[*To face p.* 771.

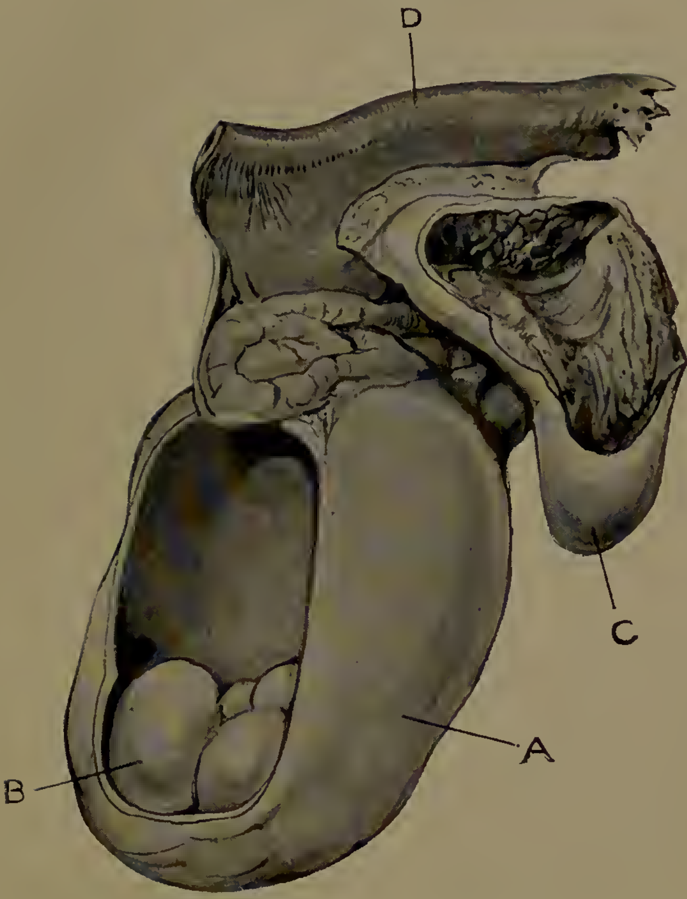
PLATE CXVI.



GIANT SCIRRHUS CARCINOMA OF THE OVARY. (AUTHOR.)

Reduced to $\frac{1}{3}$ nat. size. 12 inches in length by 27 in circumference.

PLATE CXVII.



Hydated Cyst * connected with Right Ovary. (C. J. Cullingworth.)

A, hydatids of, or attached to, right ovary, seen through the transparent cyst-wall. B, the same exposed to view by cutting out a window in the cyst-wall. C, torn remains of hydatid cyst of the right broad ligament. D, right Fallopian tube.

In this case hydatid cysts were also connected with both ovaries and the right broad ligament. The liver, omentum, and mesentery were also invaded. The pelvic cysts were first successfully removed by Cullingworth, and there were eight subsequent operations, two performed by Cullingworth and six by H. H. Clutton, for the removal of hydatid cysts from various situations (1896–1903).†

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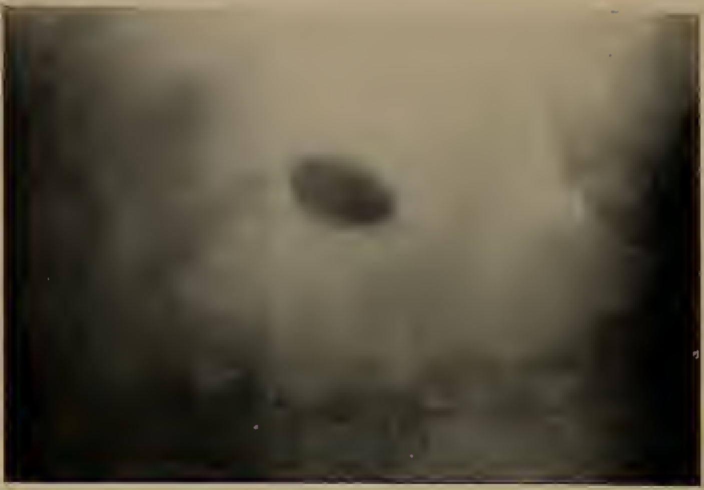
* See pp. 682, 860, 951 for hydatids of the Fallopian tube and uterus.

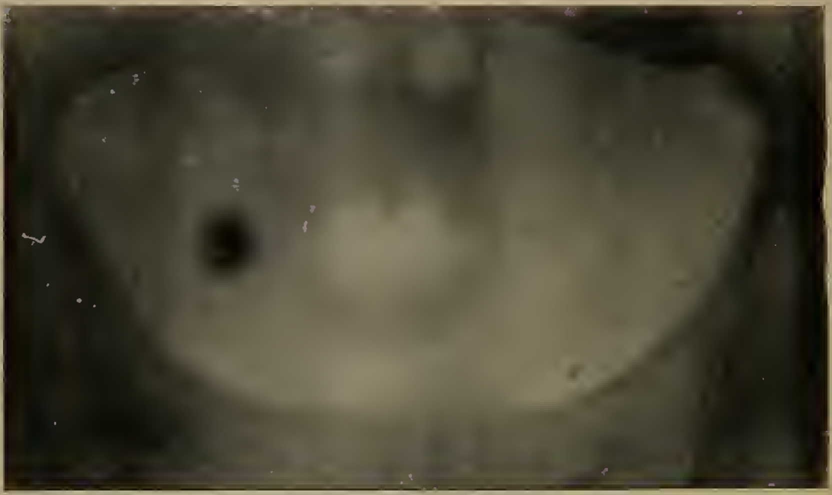
† *Jour. Obst. and Gyn. Brit. Emp.*, July, 1904.

[*To face p.* 778.

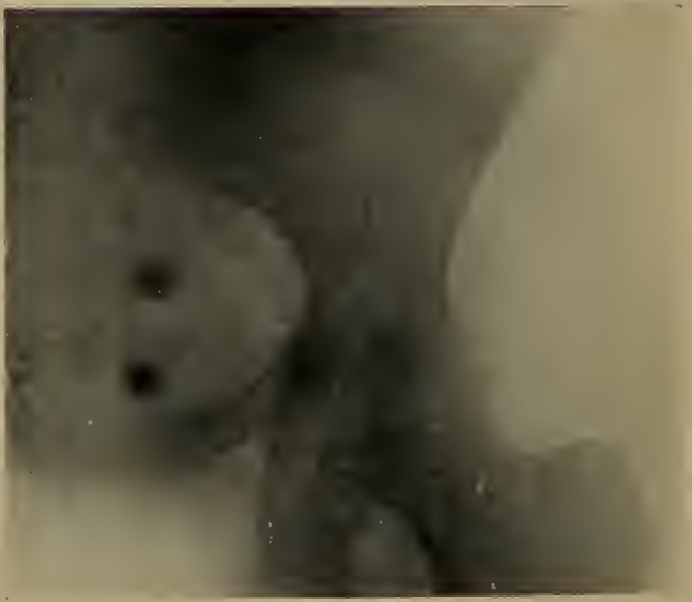
PLATES CXVIII., CXIX., CXX.



CALCULUS IN THE RIGHT KIDNEY. (SHENTON.)



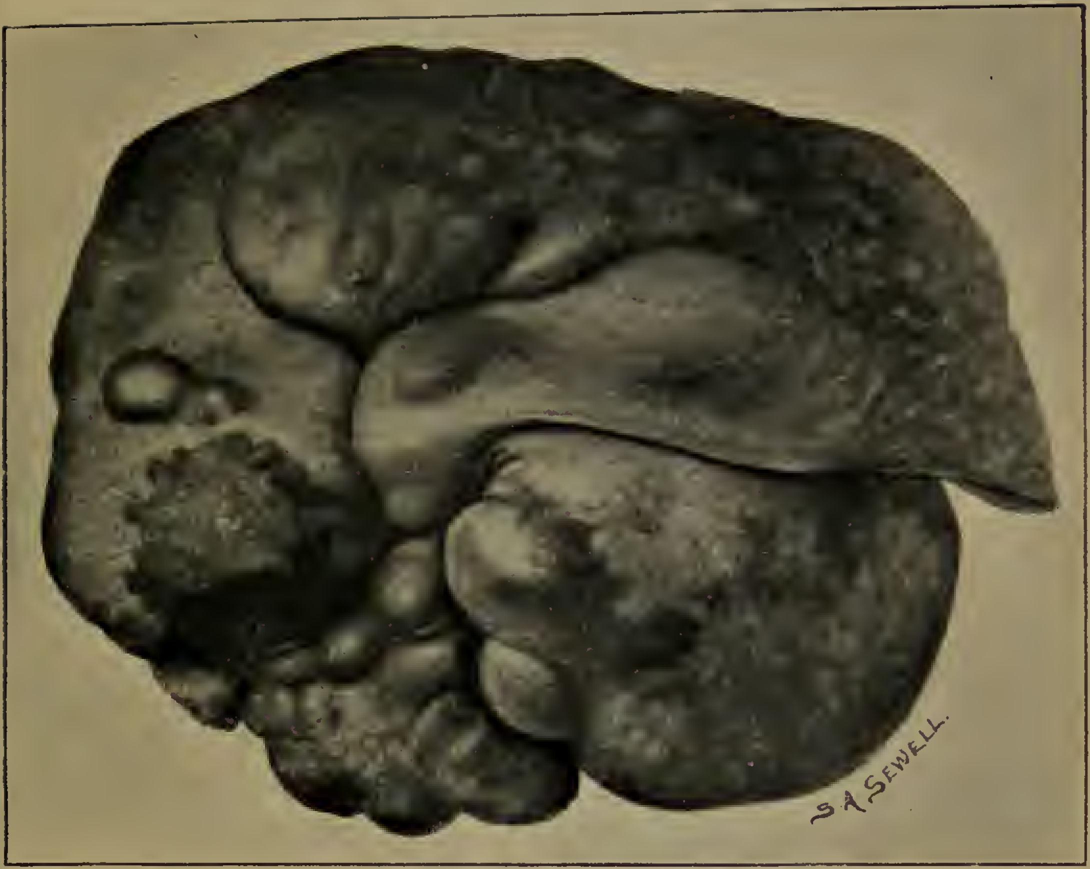
CALCULUS IN THE RIGHT URETER. (SHENTON.)



TWO CALCULI IN THE BLADDER. (SHENTON.)

[*To face p.* 894.

PLATE CXXI.



Angioma of the Liver growing from the Under Surface of the Right Lobe. Simulating a movable kidney (see also pp. 44, 45). Removed by Author. (Nat. size.) (*Vide* p. 953.)

[*To face p.* 954.

PLATE CXXII.

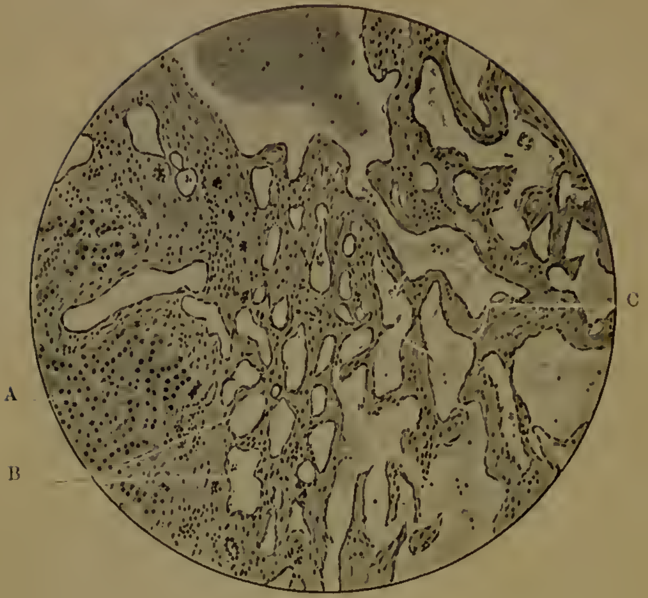


FIG. A. × 70.

A, normal liver cells; B, vascular spaces; C, a portion shown in Fig. B.

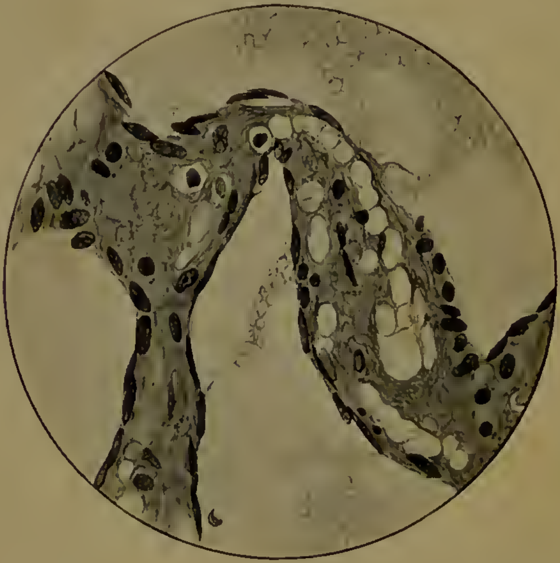


FIG. B. × 300.

Showing the vascular space, with the endothelium and blood discs (portion of C in Fig. A).

SECTIONS OF ANGIOMA OF THE LIVER.

[*To face p.* 955.

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